No. 98-1949

(15)



IN THE

# Supreme Court of the United States

LORI PEGRAM, M.D.,
CARLE CLINIC ASSOCIATION,
AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
*Petitioners,*

v.

CYNTHIA HERDRICH,
*Respondent.*

**On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit**

## JOINT APPENDIX

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November 19, 1999

PETITION FOR CERTIORARI FILED: JUNE 4, 1999
CERTIORARI GRANTED: SEPTEMBER 28, 1999



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**UNITED STATES DISTRICT COURT**
**CENTRAL DISTRICT OF ILLINOIS**
**(PEORIA)**

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Docket No. 94-CV-1143

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CYNTHIA HERDRICH,

*Plaintiff,*

v.

LORI PEGRAM, M.D., *et al.*,

*Defendants.*

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**DOCKET ENTRIES**

| DATE | NO | PROCEEDINGS |
|---|---|---|
| 3/14/94 | 1 | NOTICE OF REMOVAL from McLean County Case Number: 92-L-254 Case referred to Mag. Judge Charles H. Evans. Complaint filed 10/21/92 in McLean County. Summonses issued 10/22/92. (bn) [Entry date 03/16/94] [Edit date 03/29/94] |
| 3/14/94 | | FILING FEE PAID on 3/14/94 in the amount of $ 120.00 receipt # 014782. (bn) [Entry date 03/16/94] |
| 3/14/94 | 2 | NOTICE of Removal of Cause by Lori Pegram, Carle Clinic Assoc, Health Alliance MP (bn) [Entry date 03/16/94] |
| 3/14/94 | 3 | NOTICE of filing Notice of Removal of Cause by Lori Pegram, Carle Clinic Assoc, Health Alliance MP (bn) [Entry date 03/16/94] |
| 3/14/94 | 4 | CERTIFICATE OF INTEREST pursuant to Local Rule 1.6 filed by Lori Pegram, Carle |

| DATE | | PROCEEDINGS |
|---|---|---|
| | | Clinic Assoc, Health Alliance MIP (bn) [Entry date 03/16/94] |
| 3/17/94 | 5 | ORDER by Judge Richard Mills transferring case to the Peoria Division (cc: all counsel) (bn) |
| 3/17/94 | | Original file, certified copy of transfer order and docket sheet received from Springfield [94-3063]. Case assigned to Chief Judge Michael M. Mihm. Case referred to Mag. Judge Robert J. Kauffman. (bn) |
| 3/29/94 | 6 | TRANSFER LETTER (con mag&certificate of interest forms also to Pltf's. Atty.) sent to all attys. of record by clerk. (hw) [Edit date 03/29/94] |
| 3/29/94 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman ;cse set for telephone status conference at 4:15 p.m. on Friday, 4/29/94; court to set up call. (cc: all counsel) (ds) [Entry date 03/31/94] |
| 4/8/94 | 7 | MOTION by plaintiff Cynthia Herdrich to remand (ds) [Entry date 04/11/94] |
| 4/19/94 | 8 | MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to extend time (ds) |
| 4/22/94 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman granting motion to extend time [8-1] to respond to motion to remand [7-1]; deadline for response is 5/20/94. (cc: all counsel) (ds) |
| 4/22/94 | 9 | AMENDED MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to extend time to respond to the motion to remand to and including 5/20/94. (ds) [Entry date 04/29/94] MTNDDL 15 |



| DATE | | PROCEEDINGS |
|---|---|---|
| 4/26/94 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman ; Status hearing previously set for 4:15 on 4/29/94 is reset to Monday, 6/6/94 at 3:30 p.m. via phone, court to call. (cc: all counsel) (ds) |
| 5/20/94 | 10 | MEMORANDUM IN OPPOSITION motion to remand [7-1] by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP (ds) |
| 5/23/94 | 11 | RESPONSE in opposition by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to motion to remand [7-1] (ds) |
| 6/6/94 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman ; Attorneys Ginzkey and Brandt present via phone for status hearing held at 3:30 6/6/94 Court grants motion to extend time to respond to the motion to remand to and including [9-1] pro nunc tunc; takes under advisement on 6/6/94 motion to remand [7-1] (cc: all counsel) (ds) [Entry date 06/09/94] |
| 7/22/94 | 12 | MAGISTRATE'S RECOMMENDATION re: motion to remand [7-1] by Cynthia Herdrich by Mag. Judge Robert J. Kauffman. Recommending that motion to remand (#7) be denied and that defendants be ordered to answer Counts 3 and 4 within 10 days of the decision of the court on this motion. Case referral terminated. (cc: all counsel) (cl) [Edit date 08/22/94] |
| 8/5/94 | 13 | ORDER by Chief Judge Michael M. Mihm granting report & recommendation [12-1], and denying motion to remand [7-1]. Defendants are ordered to answer Counts 3 and 4 of the amended complaint by ; Mtn filing ddl of 8/26/94, Case referred to Mag. Judge J. Kauffman (cc: all counsel) (cl) |

| DATE | | PROCEEDINGS |
|---|---|---|
| 10/14/94 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman ; Status hearing set 9:00 Thursday, 11/3/94 by phone. Court to set up call.(cc: all counsel) (cl) |
| 11/3/94 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Attorneys Ginzkey/Brandt present by phone and ; Status hearing held 9:00 11/3/94 ;Court orderes [sic] answer to be filed within 7 days (11/10/94). Discovery to be completed by 6/30/95, ; Court sets Mtn filing ddl of 7/31/95 for filing of dispositive motions (cc: all counsel) (cl) [Entry date 11/04/94] |
| 11/8/94 | 14 | ANSWER TO ADDENDUM TO COMPLAINT by defendant Carle Clinic Assoc (cl) |
| 12/29/94 | 15 | NOTICE of Service of Discovery Documents by plaintiff Cynthia Herdrich (cl) [Entry date 12/30/94] |
| 1/17/95 | 16 | MOTION by defendant for summary judgment (cl) MTNDDL 15 [Entry date 01/18/95] |
| 1/17/95 | 17 | MEMORANDUM IN SUPPORT of motion for summary judgment [16-1] by defendants (cl) [Entry date 01/18/95] [Edit date 07/30/96] |
| 1/18/95 | 18 | NOTICE OF SERVICE OF DISCOVERY DOCUMENTS by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP (hw) |
| 2/9/95 | 19 | MOTION by plaintiff Cynthia Herdrich for extension of time (hw) |
| 2/9/95 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Plaintiff's response to motion for summary judgment was due on February 3, 1995. Plaintiff's motion for extension of time was not filed until six (6) days after the deadline. Plaintiff's counsel is put on notice that any further disregard of deadlines set in this matter will result in sanctions. The motion for extension of time [19-1] is GRANTED. Plaintiff's resepnse [sic] to motion for summary judgment [16-1] must be filed no later than 2/23/95 (cc: all counsel) (cl) [Entry date 02/10/95] |



| DATE | | PROCEEDINGS |
|---|---|---|
| 2/23/95 | 20 | RESPONSE by plaintiff Cynthia Herdrich to motion for summary judgment [16-1] with exhibits (cl) |
| 2/23/95 | 21 | MEMORANDUM IN OPPOSITION motion for summary judgment [16-1] by plaintiff Cynthia Herdrich (cl) |
| 2/23/95 | 22 | MOTION by plaintiff Cynthia Herdrich to amend complaint (cl) |
| 2/23/95 | 23 | MOTION by plaintiff Cynthia Herdrich to compel discovery (cl) |
| 3/6/95 | 24 | RESPONSE by defendants to motion to compel discovery [23-1] (cl) |
| 3/13/95 | 25 | NOTICE OF SERVICE OF DISCOVERY DOCUMENS by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP (vf) |
| 3/17/95 | 26 | REPLY by defendants to response to motion for summary judgment [16-1](d) |
| 3/20/95 | 27 | MOTION by defendant for leave to file reply in support of summary judgment (cl) |
| 3/21/95 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm granting motion for leave to file reply in support of summary judgment [27-1] (cc: all counsel) (cl) [Entry date 03/22/95] |
| 3/30/95 | 28 | 3rd AMENDED NOTICE by plaintiff Cynthia Herdrich of taking deposition of Benjamin H. Robbins on May 23, 1995 (cl) MTNDDL 15 |

| DATE | | PROCEEDINGS |
|---|---|---|
| 7/25/95 | 29 | ORDER by Chief Judge Michael M. Mihm granting in part and denying in part the motion to amend complaint [22-1], in that dft to file amended complaint as to count 3 within 14 days; granting in part and denying in part the motion for summary judgment [16-1] dismissing Count IV in favor of Dft Health Alliance with costs; to dismiss party Health Alliance MP Court sets ; Mtn filing ddl of 8/8/95 for Pla to replead Count III (see order) (cc: all counsel) (cl) |
| 8/8/95 | 30 | MOTION by plaintiff Cynthia Herdrich for leave to file to name Carle Health Insurance Management Co., Inc. as a party defendant (kw2) [Entry date 08/10/95] |
| 9/1/95 | 31 | AMENDED COMPLAINT by plaintiff Cynthia Herdrich [1-2]; adding Health Alliance MP, Carle Health Ins (cl) [Entry date 09/07/95] |
| 9/5/95 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm granting motion for leave to file to name Carle Health Insurance Management Co., Inc. as a party defendant [30-1] (cc: all counsel) (cl) |
| 9/7/95 | 32 | RESPONSE by defendant to plaintiff's motion for leave to amend [30-1] (cl) |
| 9/14/95 | 33 | WAIVER OF SERVICE returned by defendant Carle Health Ins on 9/12/95; Answers due on 1 1/13/95 for Carle Health Ins (cl) |
| 9/29/95 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm granting motion to compel discovery [23-1] as to the document production requests. If the deposition of Dr. Benjamin Robbins has not yet been scheduled, the parties are ordered to arrange that deposition within 28 days from the entry of this order. Defts likewise have 28 days to produce the requested documents. (cc: all counsel) (cl) |



| DATE | | PROCEEDINGS |
|---|---|---|
| 11/14/95 | 34 | MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP, defendant Carle Health Ins to dismiss (lr) [Entry date 11/15/95] |
| 11/14/95 | 35 | MEMORANDUM IN SUPPORT of motion to dismiss [34-1] by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP, defendant Carle Health Ins (lr) [Entry date 11/15/95] |
| 11/15/95 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm Case referred to Mag. Judge Robert J. Kauffman for further proceedings on the motion to dismiss. (cc: all counsel) (lr) [Entry date 11/16/95] |
| 11/20/95 | | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman setting hearing re motion to dismiss [34-1] at 1:30, Friday, 12/1/95 via phone. Court to call. (cc: all counsel) (lr) MTNDDL 15 |
| 11/27/95 | 36 | RESPONSE by plaintiff Cynthia Herdrich to motion to dismiss [34-1] (lr) |
| 11/27/95 | 37 | MEMORANDUM IN SUPPORT of motion response [36-1] by plaintiff: Cynthia Herdrich (lr) |
| 11/28/95 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Hearing re motion to dismiss [34-1] hearing set for 1:30, Friday, 12/1/95 is CANCELLED and RESET for 9:00, Thursday, 12/14/95 via phone. Court to call. (cc: all counsel) (lr) |
| 12/14/95 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Parties present via phone by Attys Ginzkey/Brandt for Motion hearing re: motion |

| DATE | | PROCEEDINGS |
|---|---|---|
| | | to dismiss (#34). Same held at 9:00 Thursday, 12/14/95. Argument by counsel. Court is taking under advisement on 12/14/95 motion to dismiss [34-1]. (cc: all counsel) (vf) |
| 2/5/96 | 38 | NOTICE of service of discovery documents by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP, defendant Carle Health 08/10/95] Ins (lr) |
| 3/26/96 | 39 | MAGISTRATE'S RECOMMENDATION re: motion to dismiss [34-1] by Carle Health Ins, Health Alliance MP, Carle Clinic Assoc, Lori Pegram recommended motion to dismiss [34-1] be allowed and that the plaintiff be given on last chance to re-plead the ERISA claim by Mag. Judge Robert J. Kauffman; Case referral terminated. (cc: all counsel) (lr) |
| 4/4/96 | 40 | RULE 72 OBJECTIONS by plaintiff Cynthia Herdrich to magistrate's recommendation [39-1] (vf) |
| 4/11/96 | 41 | RESPONSE by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to Rule 72 Objection [40-1] (lr) |
| 4/15/96 | 42 | ORDER by Chief Judge Michael M. Mihm denying report & recommendation objection [40-1], granting report & recommendation motion re: motion to dismiss [34-1] by Carle Health Ins, Health Alliance MP, Carle Clinic Assoc, Lori Pegram [39-1], and granting motion to dismiss [34-1]. Herdrich has 21 days from the entry of this Order to replead her Count II ERISA claim. Motion filing ddl to replead is 5/6/96. Case referred to Mag. Judge Robert J. Kauffman. (cc: all counsel) (seal) |
| 4/26/96 | 43 | MOTION by plaintiff Cynthia Herdrich to remand (lr) [Entry date 04/29/96] |



| DATE | | PROCEEDINGS |
|---|---|---|
| 5/6/96 | 44 | RESPONSE by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to motion to remand [43-1] (lr) MTNDDL 15 |
| 5/6/96 | 45 | MEMORANDUM [N SUPPORT of motion response [44-1] by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP (lr) |
| 5/10/96 | 46 | MEMORANDUM [N SUPPORT of motion to remand [43-1] by plaintiff Cynthia Herdrich (lr) |
| 5/13/96 | 47 | ORDER by Chief Judge Michael M. Mihm denying motion to remand [43-1]. Case referred to Mag. Judge Robert J. Kauffman. See Order. (cc: all counsel) (lr) |
| 5/20/96 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman; Status hearing set for 11:00, Friday, 5/31/96 via phone. Court to call. (cc: all counsel) (lr) [Entry date 05/21/96] |
| 5/31/96 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Parties present via phone by Attys Ginzkey/P Brandt for Status hearing held at 11:00 Friday, 5/31/96. Plaintiff stands on Count II as is. Parties are ready for Final Pretrial conference. (cc: all counsel/Judge Mihm) (vf) |
| 6/28/96 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm; Final Pretrial conference set for 2:00, Thursday, 8/1/96 in person in Peoria. (cc: all counsel w/FPT notice) (lr) [Entry date 07/01/96] |
| 8/1/96 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Attys. Ginzkey/Brandt present in person and final pretrial conf held 8/1/96. (Medical malpractice claims remain.) Any motions in limine and the stipulation of |

| DATE | | PROCEEDINGS |
|---|---|---|
| | | uncontested facts are to be filed by Mtn filing ddl of 8/29/96; response to motions in limine to be filed by misc ddl of 9/19/96. Jury trial set for 8:30a.m. Mond 12/2/96 (4 day trial) (cc: all counsel) (cl) [Entry date 08/02/96] |
| 8/1/96 | 48 | PRETRIAL ORDER entered by Chief Judge Michael M. Mihm : (cl) [Entry date 08/02/96] |
| 8/1/96 | 49 | EXHIBIT LIST by defendants (cl) [Entry date 08/02/96] |
| 8/1/96 | 50 | WITNESS LIST submitted by defendants (cl) [Entry date 08/02/96] |
| 8/1/96 | 51 | JURY INSTRUCTIONS submitted by defendants (cl) [Entry date 08/02/96] |
| 8/1/96 | 52 | EXHIBITS/ATTACHMENT to final pre-trial order for defendant (cl) [Entry date 08/02/96] MTNDDL 15 |
| 8/9/96 | 54 | SECOND MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP in limine to instruct the Plaintiff, her counsel, expert witnesses, and any other witnesses called on her behalf, from mentioning, r4eferring [sic] to, interrogating concerning, and/or attempting to convey to the jury that there is insurance (lr) [Entry date 08/12/96] [Edit date 08/12/96] |
| 8/9/96 | 53 | MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP in limine (lr) [Entry date 08/12/96] |
| 8/15/96 | 55 | MOTION by plaintiff Cynthia Herdrich in limine to order defendants' witnesses and attorneys from testifying, presenting evidence, arguing or suggesting Plaintiff's medical conditions unrelated to plaintiff's appendicitis etc (lr) |



| DATE | | PROCEEDINGS |
|---|---|---|
| 8/19/96 | 56 | STIPULATION STATEMENT OF UNCONTESTED FACTS AND ISSUES OF LAW by plaintiff Cynthia Herdrich (lr) [Entry date 08/21/96] |
| 11/6/96 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm setting telephone conference call re motion in limine to order defendants' witnesses and attorneys from testifying, presenting evidence, arguing or suggesting Plaintiff's medical conditions unrelated to plaintiff's appendicitis etc [55-1], motion in limine [53-1], and motion in limine to instruct the Plaintiff, her counsel, expert witnesses, and any other witnesses called on her behalf, from mentioning, referring to, interrogating concerning, and/or attempting to convey to the jury that there is insurance [54-1] at 9:00, Tuesday, 11/12/96, via phone. Court to call. (cc: all counsel) (lr) [Edit date 11/27/96] MTNDDL 15 |
| 11/12/96 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Parties present via phone by Attorneys Ginzkey/Brandt for motion hearing on Tuesday, November 12, 1996, at 9:00 a.m. re motion in limine to order defendants' witnesses and attorneys from testifying, presenting evidence, arguing or suggesting Plaintiff's medical conditions unrelated to plaintiff's appendicitis etc [55-1] and motion in limine [53-1], and motion in limine to instruct the Plaintiff, her counsel, expert witnesses, and any other witnesses called on her behalf, from mentioning, referring to, interrogating concerning, and/or attempting to convey to the jury that there is insurance [54-1]. Same held. Parties state they have discussed their motions and that neither side has any objections to the motions. Court is granting motion in limine to |

| DATE | | PROCEEDINGS |
|---|---|---|
| | | order defendants' witnesses and attorneys from testifying, presenting evidence, arguing or suggesting Plaintiff's medical conditions unrelated to plaintiff's appendicitis [55-1], motion in limine [53-1], and motion in limine to instruct the Plaintiff, her counsel, expert witnesses, and any other witnesses called on her behalf, from mentioning, referring to, interrogating concerning, and/or attempting to convey to the jury that there is insurance [54-1]. Case remains set for jury trial on Monday, December 2, 1 996, at 8:30 am. (cc: all counsel) (ml) [Edit date 11/12/96] |
| 11/20/96 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm ; Status hearing set for 1:15, Monday, 11/25/96 via phone. Court to call. (cc: all counsel) (lr) |
| 11/25/96 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Attys. Ginzkey/Brandt present by phone and status hearing held 1:15 11/25/96. Jury trial remains set 12/2/96. (cc: all counsel) (cl) |
| 11/27/96 | 57 | VOIR DIRE submitted by plaintiff Cynthia Herdrich (lr) |
| 11/29/96 | 58 | SUBPOENA filed by plaintiff Cynthia Herdrich as to Jan Kotynek, M.D. as executed (lr) [Entry date 12/02/96] |
| 12/2/96 | 59 | Proposed VOIR DIRE submitted by defendants (cl) |
| 12/2/96 | -- | MINUTE-ENTRY:by Chief Judge Michael M. Mihm. Parties present in open court, Atty Ginzkey for Pltf & Atty Brandt for Deft. Parties announce readiness. Jury trial commences 8:30 12/2/96.Prospective jurors sworn, questioned & selected (8). Preliminary instructions by court. Juror Ella Maxwell excused from |



| DATE | | PROCEEDINGS |
|---|---|---|
| | | panel. Opening statements made by counsel. Out of presence of jury, previously ruled upon motion in limine argued. Jury now present & Pltf presents evidence. Deposition of Carlton King read to jury. Jury Trial continued until 9:00am for jurors & 8:45 for attys on Tuesday, 12/3/96 (cc: all counsel) (hw) [Entry date 12/04/96] MTNDDL 15 |
| 12/2/96 | 61 | STIPULATION regarding nature of the case. (cl) [Entry date 12/05/96] |
| 12/3/96 | 60 | MEMORANDUM OF LAW on Issue of Increased Risk by defendants Lori Pegram & Carle Clinic Assoc (re:motion to exclude all evidence direct or indirect, that pltf might suffer an appendicitis attack in the future) (hw) [Entry date 12/04/96] |
| 12/3/96 | -- | MINUTE-ENTRY:by Chief Judge Michael M. Mihm. Attys Ginzkey for Pltf & Brandt for Defts present in open court for continued jury trial. Jury now present & trial resumes with further evidence presented on behalf of Pltf. Pltf rests. Jury Trial continued until Wed, 12/4/96 at 9:00am. (cc: all counsel) (hw) [Entry date 12/04/96] |
| 12/4/96 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm. Attys Ginzkey/Brandt w/parties present in person and trial continues with evidence by Dft. Dft rests. Rebuttal evidence by Pla. Pla rests. Closing arguments by counsel. Jury instructions by Court. Bailiffs sworn. Jury feed. Jury returns in open Court w/verdict at 7:55 p.m. in favor of Pla aind against Dfts for total damages of $50,000.00, with 30% negligence attributable solely to Pla, therefore $35,000 recoverable damages attributable to Pla. Jury polled. Berdicts [sic] entered of record. Jury discharged. ; Jury trial ended. Case |

| DATE | | PROCEEDINGS |
|---|---|---|
| | | terminated. Judgment to enter. (cc: all counsel) (cl) [Entry date 12/05/96] |
| 12/4/96 | 62 | EXHIBIT LIST (cl) [Entry date 12/05/96] |
| 12/4/96 | 63 | VERDICT for plaintiff Cynthia Herdrich against defendant Lori Pegram, defendant Carle Clinic Assoc (cl) [Entry date 12/05/96] |
| 12/4/96 | 64 | JURY [NSTRUCTIONS submitted to jury for deliberations (cl) [Entry date 12/05/96] |
| 12/5/96 | 65 | JUDGMENT in a civil case entered. Dfts Health Alliance Medical Plans and Carle Health Ins Co are dismissed on 4/15/96; Judgment is entered in favor of Pla and against Dfts Lori Pegram and Carle Clinic Assoc as employer of Dft Lori Pergam in the amount of $50,000 total damages with 30 % negligence attributable to pla with recoverable damages in the sum of $35,000 plus costs of suit. (cc: all counsel) (cl) |
| 12/16/96 | 66 | MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc for judgment after trial (lr) [Entry date 1 2/1 7/96] MTNDDL 15 |
| 12/16/96 | 67 | MEMORANDUM IN SUPPORT (filed as Briefing Support of post-trial motion) of motion for judgment after trial [66- 1] by defendant Lori Pegram, defendant Carle Clinic Assoc (lr) [Entry date 12/17/96] |
| 1/2/97 | 68 | MEMORANDUM IN OPPOSITION motion for judgment after trial [66-1] by plaintiff Cynthia Herdrich (lr) [Entry date 01/03/97] [Edit date 01/06/97] |
| 1/6/97 | 69 | NOTICE of APPEAL by plaintiff Cynthia Herdrich from Dist. Court decision dated 4/1 5/96 [42-3] (cc: all counsel) (lr) |
| 1/6/97 | 70 | Received appeal fee in amount of $ 105.00 (Receipt # 023566) (lr) |



| DATE | | PROCEEDINGS |
|---|---|---|
| 1/6/97 | 71 | SHORT RECORD ON APPEAL sent to USCA (lr) |
| 1/8/97 | 72 | JURISDICTIONAL DOCKETING STATEMENT filed by plaintiff Cynthia Herdrich (lr) |
| 1/14/97 | 73 | ORDER by Chief Judge Michael M. Mihm denying motion for judgment after trial [66-1]. See Order. (cc: all counsel) (lr) |
| 1/15/97 | 74 | Notification by USCA of Appellate Docket Number 97- 1 070 (lr) [Entry: date 01/16/97] |
| 1/16/97 | 75 | REPLY by defendant Lori Pegram, defendant Carle Clinic Assoc to response to motion for judgment after trial [66-1] (lr) |
| 1/27/97 | 76 | BILL OF COSTS submitted on behalf of plaintiff Cynthia Herdrich in the sum of $232.00. This notice is mailed to all parties with copy of the proposed bill of costs. Costs to be taxed at noon on Monday, 2/10/97 if not objections are filed. (hw) |
| 2/10/97 | 77 | AMENDED JUDGMENT in a civil case entered. Defts Health Alliance Medical Plans, Inc & Carle Health Ins Co., Inc are dismissed on 4/15/96. Judgment is entered in favor of Pltf & against Defts Lori Pegram & Carle Clinic Assoc as employer of Deft Lori Pegram in the sum of $50,000.00 total damages with 30% negligence attributable to Pltf Cynthia Herdrich with recoverable damages in the sum of $35,000.00 plus costs of suit. Further that on 2/10/97, costs are taxed in favor of Pltf & against Defts in the sum of $232.00 (cc: all counsel) (hw) |
| 4/4/97 | 78 | SATISFACTION OF JUDGMENT as to defendant Carle Clinic Assoc (lr) [Entry date 04/07/97] |

| DATE | | PROCEEDINGS |
|---|---|---|
| 5/27/97 | 79 | MOTION by plaintiff Cynthia Herdrich for order to withdraw record (vg) [Entry date 05/28/97] MTNDDL 15 |
| 5/29/97 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm granting motion for order to withdraw record [79-1] (cc: all counsel) (vg) |
| 5/30/97 | 80 | RECEIPT to Atty James P Ginzkey with one volume of pleadings of record on appeal (vg) |
| 6/5/97 | 81 | RECEIPT from Atty Ginzkey of receipt of record on appeal (vg) |
| 7/18/97 | 82 | STIPULATION regarding transfer of record from defendant's counsel to plaintiff's counsel. (vg) [Entry date 07/21/97] |
| 7/22/97 | -- | MINUTE-ENTRY: by Chief Judge Michael M. Mihm. On July 18, 1997, the parties in this action flied a stipulation regarding the transfer of the record from one counsel to the other in order to prepare appellate briefs. However, despite the agreement of counsel, this procedure is inappropriate and contrary to the procedure set forth in Local Rule 79.2. Accordingly, counsel in possession of the record must return it to the Clerk's Office, who will then facilitate the transfer of the record to opposing counsel as per the standard operating procedure of this Court in accordance with the Local Rules. (cc: all counsel) (vg) |
| 7/29/97 | 83 | Remark-received from James P Ginzkey the record on appeal consisting of one volume of pleadings (vg) [Entry date 07/30/97] |
| 10/21/97 | 84 | NOTICE of oral argument from CA 7 with request for record on appeal (vg) |
| 10/22/97 | 85 | Letter of transmittal to USCA with one volume of pleadings (vg) |



| DATE | | PROCEEDINGS |
|---|---|---|
| 10/22/97 | -- | CLERK'S RECORD on appeal transmitted to USCA consisting of one volume of pleadings (vg) |
| 11/3/97 | 86 | Letter of transmittal from USCA acknowledging receipt of 1 vol of ROA (kd) [Edit date 11/04/97]. |
| 12/9/98 | 87 | COPY of USCA Order: It is ordered that the aforesaid petition for rehearing be, and the same hereby is, DENIED. (ww) |
| 12/11/98 | 88 | COPY of USCA Order: The court, on its own motion, hereby withdraws the order of 12/7/98 in the case Herdrich v. Pegram. (ww) |
| 12/17/98 | 89 | MANDATE from USCA denying petition for rehearing [69-1]. ORDERED that the aforesaid petition for rehearing be, and the same hereby is, DENIED. (ml) |
| 12/17/98 | -- | RECORD ON APPEAL returned from U.S. Court of Appeals consisting of one volume of pleadings. (ml) MTNDDL 15 [Entry date 01/29/99] |
| 1/8/99 | 90 | USCA Order: The Court, on its own motion, VACATED the mandate and Bill of Costs of 12/15/98 as erroneously issued. (ww) |
| 1/29/99 | -- | CLERK'S RECORD on appeal transmitted to USCA again pursuant to telephone call from CA-7 requesting it due to order vacating mandate. (ml) |
| 2/3/99 | 91 | RECEIPT for Complete Record on Appeal by UCSA (sh) |
| 3/17/99 | -- | RECORD ON APPEAL returned from U.S. Court of Appeals consisting of one volume of pleadings (ww) |
| 3/22/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm. Case set for Status hearing re:mandate |

| DATE | | PROCEEDINGS |
|---|---|---|
| | | on Tuesday, 3/23/99 at 3:00 pm; via phone, Court to set up the call. (cc: all counsel) (hw) |
| 3/23/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm. Parties present via phone by Attorneys Ginzkey/Brandt for Status hearing at 3:00 pm on Tuesday, 3/23/99. Same held with discussion re: mandate. Case is set for Supplemental Rule 16 Conference at 4:00 pm on Friday, 4/9/99, via phone. Court to call. (cc: all counsel) (ml) [Entry date 03/25/99] |
| 4/7/99 | 92 | PROPOSED DISCOVERY PLAN filed by plaintiff Cynthia Herdrich and defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MP and Carle Ins (ww) |
| 4/9/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm. Attys Ginzkey/ Brandt present by phone and Supplemental Rule 16 conference held 4:00 4/9/99. Plaintiff to amend pleadings/join parties no later than 7/1/99; fact discovery to be completed by 8/1/99; plaintiff to disclose expert by 8/1/99; expert to be deposed by 9/1/99; defendant to disclose expert by 11/1/99 and expert to be deposed by 12/1/99. All discovery to close 12/1/99. Dispositive motions to be filed no later than Mtn filing ddl of 12/1/99; response to be filed by misc ddl of 12/22/99. Final Pretrial conference set 1:00 p.m. Friday, 2/25/2000 in person in Peoria. Jury trial set 8:30a.m. Monday, 3/27/2000 in Peoria. Status hearing set at 4:45p.m. Wednesday, 7/7/99 by phone. Court to set up call. (cc: all counsel) (ci) [Entry date 04/1 3/99] [Edit date 05/03/99] |
| 4/9/99 | -- | ENDORSED ORDER on its face by Judge Michael M. Mihm adopting proposed Rule 16 schedule #92 with changes. (See order) (cc: all counsel). (cl) [Entry date 04/13/99] |



| DATE | | PROCEEDINGS |
|---|---|---|
| 4/26/99 | 93 | MOTION by defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MP and Carle Health Ins to stay (ww) MTNDDL 15 |
| 4/26/99 | 94 | BRIEF IN SUPPORT of motion to stay [93-1] by defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MP and Carle Ins (ww) |
| 4/30/99 | 95 | RESPONSE in Opposition by plaintiff Cynthia Herdrich to motion to stay [93-1](ww) |
| 4/30/99 | 96 | MEMORANDUM IN SUPPORT of opposition [95-1] to stay [93-1] filed as a brief by plaintiff Cynthia Herdrich (ww) |
| 4/30/99 | 97 | 2ND MOTION by plaintiff Cynthia Herdrich to compel (ww) |
| 5/6/99 | 98 | RESPONSE by defendants Lori Pegram, Carle Clinic Assoc and Health Alliance MP to second motion to compel [97-1] (ww) |
| 5/21/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm. Defendant's motion to stay [93-1] is DENIED. Additionally, Plaintiff's motion to compel [97-1] is GRANTED. Defendant's sole argument in response to the motion to compel is that the "motion is untimely and premature since the question whether Plaintiff's complaint states a cause of action. . . remains unanswered." The question has been answered, as the Seventh Circuit issued its mandate. Furthermore, because the Seventh Circuit issued its mandate, Fed. R. Civ. P. 27(b) is inapplicable. Consequently, discovery in this case will progress in accordance with the schedule established by the Court on 4/9/99. This case is referred to the Mag. Judge Robert J. Kauffman. (cc: all counsel) (ww) |
| 6/22/99 | 99 | STIPULATED MOTION by pla Cynthia Herdrich and dfts Lori Pegram, Carle Clinic As- |

| DATE | | PROCEEDINGS |
|---|---|---|
| | | soc, Health Alliance MP and Carle Health Ins to amend rule 16 schedule (ww) |
| 7/7/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm. Attys Ginzkey/ Steitz (for Brandt) present by phone and status hearing held 4:45 7/7/99. Court is granting motion to amend Rule 16 schedule [99-1]. Court resets schedule of case as follows: Previous discovery schedule is vacated. All discovery closes 2/15/00. Dispositive motions to be filed no later than Mtn filing ddl of 3/10/00; response to be filed by misc ddl of 3/31/00. Any reply to be filed by 4/7/00. Final pretrial conference is reset to 1:00 Friday, 6/16/00 in person in Peoria. Jury trial is reset to 8:30 Monday, 8/21/00 in Peoria. Case to be set for settlement conference at a time to be determined by Magistrate Judge Robert J. Kauffman. (cc: all counsel/ Prob/USM/ Crt Rptr) (cl) [Entry date 07/08/99] |
| 7/8/99 | 100 | AMENDED RULE 16 Schedule by Judge Michael M. Mihm. Discovery to be completed by 2/15/00. Final Pretrial conference set at 1:00 p.m. on Wednesday, 6/16/00 in person. Jury trial set at 8:30 am. on Monday, 8/21/00 in person. Dispositive motion filing ddl of 3/10/00. Replys to be filed by 4/7/00. (cc: all counsel) (ww) MTNDDL 15 |
| 7/16/99 | 101 | MOTION by defendant Lori Pegram, defendant Carle Clinic Assoc, defendant Health Alliance MP to continue/reschedule final pretrial conference (hw) |
| 7/16/99 | 102 | AFFIDAVIT of Peter W. Brandt regarding motion to continue/reschedule final pre-trial conference [101-1] (hw) |
| 7/27/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm. Defendants' motion to continue/re- |



| DATE | | PROCEEDINGS |
|---|---|---|
| | | schedule final pre-trial conference [101-1] is GRANTED. The Court will contact the parties shortly to reschedule the conference. (cc: all counsel) (ww) [Entry date 07/28/99] |
| 7/28/99 | 103 | NOTICE by plaintiff Cynthia Herdrich of service of discovery documents |
| 7/30/99 | 104 | MOTION by defendants Lori Pegnam, Carle Clinic Assoc and Health Alliance MP to strike jury demand (ww) |
| 7/30/99 | 105 | MEMORANDUM IN SUPPORT of motion to strike jury demand [104-1] by defendants Lori Pegram, Carle Clinic Assoc and Health Alliance MP (ww) |
| 8/3/99 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman setting motion hearing in re motion to strike jury demand [104-1] at 9:30 am. on Monday, 8/23/99 via phone. Court to set up the call. (cc: all counsel) (ww) |
| 8/3/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm. Final pretrial conference previsouly [sic] scheduled on 6/16/00 (canceled in minute entry of 7/27/99) is rescheduled to Wednesday, 6/14/00 at 4:30 p.m. in person. (cc: all counsel) (ww) |
| 8/9/99 | 106 | RESPONSE by plaintiff Cynthia Herdrich to motion to strike jury [104-1] (ww) |
| 8/10/99 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman granting motion to strike jury demand [104-1] (cc: all counsel) (ww) |
| 8/12/99 | 107 | NOTICE of service of discovery documents by defendants Lori Pegram, Carle Clinic Assoc and Health Alliance MP (ww) |
| 8/17/99 | -- | MINUTE-ENTRY: by Mag. Judge Robert J. Kauffman. Motion hearing set 8/23/99 at 9:30 am. in re motion to strike jury demand [104-1] |

| DATE | | PROCEEDINGS |
|---|---|---|
| | | is cancelled per ruling on motion on 8/10/99. (cc: all counsel) (ww) |
| 9/1/99 | 108 | MOTION by plaintiff Cynthia Herdrich to extend time to complete fact discovery and expert disclosure (ww) MTNDDL 15 |
| 9/3/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm setting motion to extend time to complete fact discovery and expert disclosure [108-1] for hearing at 1:00 p.m. on Tuesday, 9/7/99, via phone. Court to call. (cc: all counsel) (ml) |
| 9/7/99 | 109 | NOTICE of service of discovery documents by defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MIP, and Carle Health Ins (ww) |
| 9/7/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm. Parties present via phone by Attorneys Ginzkey/Peter Brandt for motion Hearing on Tuesday, September 7, 1999, at 1:00 p.m. re motion to extend time to complete fact discovery and expert disclosure [108-1]. Same held. Court is granting motion to extend time to complete fact discovery and expert disclosure [108-1] and sets the following schedule: Disclosure of plaintiff's experts to be completed by 11/12/99 and plaintiff's expert discovery to be completed by 12/24/99. Defendants' experts to be disclosed by 1/14/2000. Fact discovery deadline is 10/29/99. The deadline for the close of all discovery remains unchanged at 2/15/2000. (cc: all counsel) (ml) |
| 10/1/99 | 110 | RENEWED MOTION by defendants Lori Pegram, Carle Clinic Assoc, Health Alliance MIP and Carle Health Ins for stay (ww) |
| 10/1/99 | 111 | BRIEF/MEMORANDUM IN SUPPORT of motion for stay [110-1] by defendants Lori |



| DATE | | PROCEEDINGS |
|---|---|---|
| | | Pegram, Carle Clinic Assoc, Health Alliance MP and Carle Ins (ww) |
| 10/6/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm setting case for motion hearing on renewed motion for stay [110-1] at 2:00 p.m. on Thursday, 10/7/99, via phone. Court to call. (cc: all counsel) (ml) [Entry date 10/07/99] |
| 10/7/99 | -- | MINUTE-ENTRY: by Judge Michael M. Mihm. Parties present via phone by Attorneys Ginzkey/Brandt for motion hearing at 2:00 p.m. on Wednesday, October 7, 1999 re Defendants' renewed motion for stay [110-1]. Same held. Order will enter ordering case stayed until Supreme Court rules on it. (cc: all counsel) (ml) |
| 10/7/99 | 112 | ORDER by Judge Michael M. Mihm granting defendants' renewed motion for stay [110-1]. ORDERED that this action is STAYED pending the Supreme Court's disposition of Pegram v. Herdrich, No. 98-1949. (cc: all counsel) (ml) |

**UNITED STATES COURT OF APPEALS**
**FOR THE SEVENTH CIRCUIT**

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Docket No. 97-1070

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CYNTHIA HERDRICH,
*Plaintiff-Appellant,*
v.
LORI PEGRAM, M.D., *et al.*,
*Defendants-Appellees.*

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**DOCKET ENTRIES**

| DATE | PROCEEDINGS |
|---|---|
| 1/10/97 | Private civil case docketed. [97-1070] [907331-1] Appearance form due on 2/10/97 for Peter W. Brandt, for James P. Ginzkey. Transcript information sheet due 1/21/97. Appellant's brief due 2/19/97 for Cynthia Herdrich. Docketing Statement due 1/13/97. (tim) |
| 1/17/97 | Filed Appellant Cynthia Herdrich docketing statement. [97-1070] [909045-1] (chuc) |
| 1/27/97 | NOTICE: Peter W. Brandt for Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram will not be available for oral argument March 21 - April 4, 1997. [97-1070] [907331-1] (broo) |
| 1/27/97 | Appearance form filed by attorney(s) James P. Ginzkey for Appellant Cynthia Herdrich. [97-1070] [907331-1] (madd) |
| 2/4/97 | Appearance form filed by attorney(s) Peter W. Brandt for Appellee Lori Pegram, Appellee Carle Clinic Assoc, Appellee Health Alliance. [97-1070] [907331-1] (madd) |



| DATE | PROCEEDINGS |
|---|---|
| 2/6/97 | ORDER: On review of the short record, it appears that a timely post-decision motion was filed in the District Court. Appellant(s) shall file a jurisdictional memorandum addressing the consequences of Rule 4(a) (4) on our jurisdiction. A motion for voluntary dismissal pursuant to FRAP 42(b) will satisfy this requirement. [907331-1] DW [97-1070] [920531-1] Briefing is SUSPENDED pending further court order. (See order for further details) Jurisdictional memorandum due 2/19/97 for Cynthia Herdrich. (tim) |
| 3/4/97 | ORDER issued: The court is informed that counsel for the appellant did not receive a copy of the court's 2/6/97 jurisdictional order. Accordingly, the clerk of this court is directed to reissue that order. The appellant's jurisdictional memorandum is due 3/18/97. AM [97-1070] (elea) |
| 3/18/97 | Filed Appellant Cynthia Herdrich jurisdictional memorandum. [97-1070] [928587-1] (tim) |
| 3/25/97 | ORDER: Upon consideration of appellant's JURISDICTIONAL MEMORANDUM, IT IS ORDERED that briefing will proceed as follows: [928587-1] AM [97-1070] Appellant's brief due 4/23/97 for Cynthia Herdrich. Appellee's brief due 5/23/97 for Lori Pegram, for Carle Clinic Assoc, for Health Alliance. Appellant's reply brief due 6/6/97 for Cynthia Herdrich. (patb) |
| 3/25/97 | ORDER: Pursuant to FRAP 33, briefing will proceed as follows: [928587-1] SCO [97-1070] Appellant's brief due 5/5/97 for Cynthia Herdrich. Appellee's brief due 6/4/97 for Lori Pegram, for Carle Clinic Assoc, for Health Alliance Appellant's reply brief due 6/18/97 for Cynthia Herdrich. (patb) |
| 4/3/97 | ORDER: The court, on its own motion, is VACATING the briefing order of 3/25/97 setting a |

| DATE | PROCEEDINGS |
|---|---|
| | due date of 4/23/97 for the brief of the appellant. The court's order of 3/25/97 setting a due date of 5/5/97 for the filing of a brief by the appellant remains in effect. [907331-1] AM [97-1070] (elea) |
| 4/8/97 | ORDER: The court, on its own motion, is VACATING the briefing order of 3/25/97 which set the appellant's brief date as 4/23/97. Briefing shall proceed to the 3/25/97 order setting the appellant's due date as 5/5/97. [907331-1] AK [97-1070] (grac) |
| 5/2/97 | ORDER: Pursuant to F.R.A.P. 33, it is advised that the briefing schedule is modified as follows: [907331-1] DW [97-1070] Appellant's brief due 6/6/97 for Cynthia Herdrich. Appellees' brief due 7/7/97 for Lori Pegram, Carle Clinic Assoc and Health Alliance. Appellant's reply brief due 7/21/97 for Cynthia Herdrich. (nanc) |
| 5/20/97 | ORDER: Pursuant to F.R.A.P. 33, the briefing schedule is modified as follows: [928587-1] SCO [97-1070] Appellant's brief due 6/13/97 for Cynthia Herdrich. Appellees' brief due 7/14/97 for Lori Pegram, Carle Clinic Assoc and Health Alliance. Appellant's reply brief due 7/28/97 for Cynthia Herdrich. (nanc) |
| 6/13/97 | Brief deficiency letter sent to Appellant Cynthia Herdrich. [907331-1] [97-1070] (tyle) |
| 6/13/97 | Filed 15c appellant's brief by Cynthia Herdrich. Disk filed. [97-1070] [960879-1] (elea) |
| 7/16/97 | Filed 15c appellee's brief by Health Alliance, Carle Clinic Assoc, Lori Pegram. Disk filed. [97-1070] [971512-1] (dorh) |
| 7/17/97 | Filed motion by Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram for damages, costs. [969469-1] and, for award of attorney's fees. [969469-2] [97-1070] (orac) |



| DATE | PROCEEDINGS |
|---|---|
| 7/24/97 | IT IS ORDERED that the following motion(s) and/or document(s) shall be taken with the case for determination by the merits panel: MOTION OF APPELLEES FOR DAMAGES, COSTS, AND FEES. The clerk will distribute these items and a copy of this order to the panel. [0-0] MAF [97-1070] (jenp) |
| 7/28/97 | Filed 15c appellant's reply brief by Cynthia Herdrich. Disk filed. [97-1070] [971508-1] (dorh) |
| 10/17/97 | ORDER: Argument set for Tuesday, December 2, 1997 at 9:30 a.m. Each side limited to 20 minutes. [97-1070] [997352-1] (broo) |
| 10/27/97 | Original record on appeal filed. Contents of record: 1 vol. pleadings; . [97-1070] [1000914-1] (odea) |
| 11/13/97 | ORDER: Argument reset for Tuesday, December 2, 1997 at 9:30 a.m. Each side limited to 15 minutes. [97-1070] [1006028-1] (broo) |
| 12/2/97 | Case heard and taken under advisement by panel: Circuit Judge Harlington Wood, Circuit Judge John L. Coffey, Circuit Judge Joel N. Flaum. [97-1070] [1012276-1] (broo) |
| 12/2/97 | Case argued by James P. Ginzkey for Appellant Cynthia Herdrich, Peter W. Brandt for Appellee Lori Pegram, Appellee Carle Clinic Assoc, Appellee Health Alliance [97-1070] [907331-1] (broo) |
| 8/18/98 | Filed opinion of the court by Judge Coffey. REVERSED and REMANDED for further proceedings. Circuit Judge Harlington Wood, Circuit Judge John L. Coffey, Circuit Judge Joel N.Flaum, dissenting. [97-1070] [907331-1] (orac) |
| 8/18/98 | ORDER: Final judgment filed per opinion. With costs: y. [97-1070] [1091772-1] (orac) |

| DATE | PROCEEDINGS |
|---|---|
| 8/27/98 | Filed Appellant Cynthia Herdrich Bill of Costs in the amount of $433.26. [97-1070] [907331-1] (fran) |
| 9/1/98 | Filed 30c Petition for Rehearing with Suggestion for Rehearing Enbanc by Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram. Dist. [97-1070] [1096386-1] (joce) |
| 9/3/98 | Sent clerk's copy of request to Appellant Cynthia Herdrich requesting 30c of their Answer to the Petition for Rehearing with Suggestion for Rehearing Enbanc filed by the Appellees on 9/1/98. [97-1070] [1096668-1] Answer to Petition for Enbanc Rehearing due 9/17/98 for Cynthia Herdrich. (jame) |
| 9/3/98 | Filed Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram objection to Appellant Cynthia Herdrich's bill of costs. [97-1070] [1097039-1] (joce) |
| 9/11/98 | Objection to amended bill of costs filed by Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram. [97-1070] [907331-1] (joce) |
| 9/17/98 | Filed motion by Appellant Cynthia Herdrich to supplement her answer by inserting a certificate of interest, table of contents and table of cases and statutes. [1100733-1] 15c inserts tendered. [1100733-1] [97-1070] (joce) |
| 9/21/98 | ORDER issued DENYING motion to supplement. [1100733-1] AK [97-1070] Counsel shall rebind the Answer to the Petition to contain all the proper items and refile by 9/22/98 for Cynthia Herdrich. (heid) |
| 9/21/98 | Filed 30c Answer of Appellant Cynthia Herdrich to Petition for Rehearing with Suggestion for Rehearing Enbanc. Dist. [97-1070] [1101640-1] (joce) |



| DATE | PROCEEDINGS |
|---|---|
| 9/25/98 | ORDER issued DENYING as MOOT the objections to the bill of costs and amended bill of costs. [1097039-1] NM [97-1070] (joce) |
| 12/7/98 | ORDER: Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram Petition for Rehearing with Suggestion for Rehearing Enbanc is DENIED. A vote fo the active members of the Court was requested. A majority did not favor rehearing en banc. Chief Judge Posner and Circuit Judges Flaum, Easterbrook, and Diane P. Wood voted to grant rehearing en banc. A majority of the judges on the original panel voted to deny rehearing en banc. [97-1070] [1096386-1] (joce) |
| 12/8/98 | ORDER: The court, on its own motion, hereby WITHDRAWS the order of 12/7/98, in the case Herdrich V. Pegram. [97-1070] (heid) |
| 12/14/98 | Certificate of interest filed by Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram. [97-1070] [907331-1] (joce) |
| 12/14/98 | Terminated attorney Peter W. Brandt for Lori Pegram, attorney Peter W. Brandt for Carle Clinic Assoc, attorney Peter W. Brandt for Health Alliance and added attorney Richard D. Raskin per appearance form. Appearance form filed for Appellee Health Alliance, Appellee Carle Clinic Assoc, Appellee Lori Pegram by attorney Richard 0. Raskin. [97-1070] [907331-1] (joce) |
| 12/15/98 | MANDATE ISSUED WITH BILL OF COSTS IN THE AMOUNT OF $433.26. [97-1070] [907331-1] (cove) |
| 12/18/98 | ORDER issued. The mandate in this cause is VACATED, erroneously issued. [97-1070] [907331-1] (joce) |
| 12/22/98 | Filed mandate receipt. [97-1070] [1131138-1] (tina) |

| DATE | PROCEEDINGS |
|---|---|
| 1/5/99 | ORDER: The court, on its own moiton [sic], VACATES the mandate and Bill of Costs of 12/15/98 as erroneously issued. [97-1070] [907331-1] (hard) |
| 2/1/99 | Original record on appeal filed. Contents of record: 1 vol. pleadings; . [97-1070] [1143117-1] (odea) |
| 3/5/99 | Filed motion by Appellant Cynthia Herdrich to expedite ruling on defendants/appellees motion to reconsider. [1154961-1] [97-1070] (squi) |
| 3/8/99 | Opinion filed DENYING Appellees Health Alliance, Carle Clinic Assoc, and Lori Pegram's Petition for Rehearing with Suggestion for Rehearing Enbanc. Enbanc, Circuit Judge Frank H. Easterbrook, with whom Chief Judge Richard A. Posner, and Circuit Judges Joel N. Flaum and Diane P. Wood, join, dissenting from the denial of rehearing en banc. [97-1070] [1096386-1] (jame) |
| 3/16/99 | MANDATE ISSUED AND ENTIRE RECORD RETURNED. (Contents returned: 1 vol. pleadings;.) [97-1070] [928587-1] (cove) |
| 3/19/99 | Filed mandate receipt. [97-1070] [1159114-1] (tina) |
| 4/8/99 | ORDER issued DENYING as MOOT the motion to expedite ruling. On 3/8/99, this court denied the Petition for Rehearing and Suggestion for Rehearing En Banc. [1154961-1]NM[97-1070] (joce) |
| 6/11/99 | Filed notice from the Supreme Court of the filing of a Petition for Writ of Certiorari. Supreme Court Case No.: 98-1949. [97-1070] [1187445-1] (kell) |
| 10/1/99 | Filed order from the Supreme Court GRANTING the Petition for Writ of Certiorari. Supreme Court Case No.: 98-1949. [97-1070] [1220172-1] (squi) |



# GROUP MEDICAL HEALTH PLAN
# SUMMARY PLAN DESCRIPTION
# 01-01-91

## SUMMARY PLAN DESCRIPTION OF THE EMPLOYEES AND AGENCY MANAGERS GROUP MEDICAL HEALTH PLAN

Section I of the Group Medical Health Plan description applies to the Health Maintenance Organizations (HMO) option and to the Group Medical Insurance option.

Section II provides information exclusive to the Group Medical Insurance option.

Section III and the Appendix provides information exclusive to the HMO option.

## TABLE OF CONTENTS



Exc=Exclusion
Def=Definition





Exc=Exclusion
Def=Definition

Exc=Exclusion
Def=Definition





Exc=Exclusion
Def=Definition

How To Obtain HMO Information
Termination of Benefits
Premium Shared
Detailed Information On HMOs Offered in Your Area

Exc=Exclusion
Def=Definition



## NOTICE REGARDING CONTINUATION OF GROUP MEDICAL INSURANCE/HMO COVERAGE

As of January 1, 1987, if you are enrolled in a health care plan and your coverage terminates, you may be able to arrange to continue the coverage. The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers to offer continuation of health coverage to individuals willing to pay the entire premium. The plans affected by this Act are: State Farm Group Medical Health Plan (Group Medical Insurance and Health Maintenance Organizations-HMOs.), State Farm Group Dental, and the Medical Expense Reimbursement Plan (MER).

The chart below lists the reasons (qualifying events) for loss of coverage and the length of time coverage can be extended.

| Individual Covered | Reasons for Loss of Coverage | Continued For |
|---|---|---|
| EMPLOYEE (and covered dependents) | Termination for any reason other than gross misconduct | 18 Months |
| | Reduction of work hours | |
| SPOUSE (and covered dependents) | Death of employee, divorce or legal separation from employee, or employee's eligibility for Medicare | 36 Months |
| DEPENDENT | Individual ceases to be a dependent under the terms of the plan | 36 Months |

Election of continuation must be made within 60 days of loss of coverage as described above.

Since the company has no way of knowing when a member divorces, legally separates or a child becomes ineligible for coverage; it is your responsibility to notify the Personnel Department and request continuation of coverage within 60 days of the event causing the loss of coverage and/or 60 days

from the date coverage ceases. Once you've notified the Personnel Department of your request, the continuation election and premium payment procedures will be provided.

If you choose to continue your coverage, it will continue until the earlier of any one of the following events:

1. The end of the number of months on the chart above (or, if you, the State Farm Associate are disabled at the time of your termination or reduction in hours, you may receive up to 29 months).
2. The premium for the continued coverage is not paid on or before the due date.
3. The covered person becomes eligible for Medicare (however, if you, the State Farm Associate, become entitled to Medicare while under continuation coverage, your eligible dependents may be entitled to an additional 36 months of continuation coverage).
4. The covered person becomes covered under another group health plan (unless that plan contains a pre-existing exclusion or limitation that would specifically limit coverage for any pre-existing condition that you or any eligible dependent may have).
5. State Farm terminates all of its group health plans.

NOTE: If a former spouse or surviving spouse of a State Farm employee, agency manager or trainee agent is age 55 at the time of the event causing the loss of active coverage, he/she may participate in continuation coverage until the earlier of the following:

1. His/her entitlement to Medicare or attainment of the qualifying age for Medicare.
2. The premium for the continued coverage is not paid on or before the due date.



3. He/she remarries (this alone will not terminate the continuation coverage until after the original 36 months)
4. He/she becomes covered under other employer group insurance.

## EXTENSION OF CERTAIN BENEFITS UPON TERMINATION OF INSURANCE

1. In the event of an insured retired employee's death, his or her spouse may continue to be covered.
2. Coverage may be provided for the spouse of an employee who dies prior to retirement if the employee was participating in the group medical plan and had at least 5 years of credited service on the employee's Retirement Plan and whose age plus years of credited service equalled 55 on the date of death.

   With respect to items 1. and 2. above, during any period that either the retired employee or spouse is insured, the retired employee's never married children, as defined on page 4100, may also be insured provided the never married children are dependent upon the surviving spouse for a majority of their support.
3. If on the date of termination of this Policy an insured individual is totally disabled by an Illness, coverage will be extended during the subsequent period of continuous total disability but for no longer than 12 monhts [sic] after the date the Policy terminates. Coverage will be extended solely for Illness(es) incurred prior to the termination of this Policy.
4. When an employee's insurance under this Policy terminates because of termination of employment or membership within the eligible classes for benefits under this Policy, the employee may be entitled to have his/her

coverage and dependents' coverage continued under this Policy.

Illinois law provides:

a. The employee must have been continuously insured for at least three months under this Policy.

b. This election must be made within the ten-day period following the later of:

   i. the date of termination of insurance, or

   ii. the date the employee is given written notice of the right of continuation,

   but in no event later than 60 days after the date of termination of insurance.

c. Premiums be paid on a monthly basis in advance to State Farm. Coverage may be continued until the earliest of the following dates:

   i. the date 9 months after the termination of coverage;

   ii. the date the employee becomes eligible for Medicare;

   iii. the end of the period for which premium was paid if the employee fails to make the advance premium payment;

   iv. the date the employee becomes eligible for coverage under any other group insured or uninsured hospital, surgical or medical expense plan;

   v. the date this group Policy is terminated; or

   vi. the date the employee elects to exercise the conversion privilege.



d. Continuation will not be available for any employee who was discharged because of the commission of a felony in connection with his/her work, or because of theft in connection with his/her work, for which the employer was in no way responsible; provided the employee admitted his/her commission of the felony or theft or such act has resulted in a conviction or order of supervision.

5. In the event of an insured employee's death or divorce from an insured Employee, the former covered spouse is entitled to have his/her coverage and dependents' coverage continued under this Policy, provided such spouse complies with the conditions stated below. Failure by the former spouse to comply with these conditions terminates the right to continue coverage.

   a. The spouse must provide written notice to the Personnel Department of dissolution of marriage or death within 30 days of the divorce or death of the employee.

   b. Upon receipt of this notice, the Personnel Department will provide the former spouse with an election form which describes the amount of premium and method and place of payment.

   c. The election forms must be returned fully completed by certified mail, return receipt requested, within 30 days after the receipt of the forms by the former spouse.

If you have any questions about continuation coverage, please contact the Plan Administrator, Group Medical Continuation, Corporate Benefits and Services, State Farm Insurance, One State Farm Plaza, Bloomington, IL 61710-0001.

JAMES E. RUTROUGH

VICE PRESIDENT-PERSONNEL

## MEMBER RIGHTS AND PROTECTIONS UNDER ERISA:

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans such as the plan described in this booklet. As in the past, the Company fully intends to support your rights. Nevertheless, federal law and regulations require that a statement of ERISA rights be included in this description of your plan.

As a participant in the Group Medical Health Plan, you have the following rights:

You may examine, without charge, all plan documents—including any insurance contracts, annual reports, plan descriptions, and other documents filed with the Department of Labor. All documents are available for review by you or your Dependents in the General Personnel Department, Corporate Headquarters, and Regional Personnel Departments during normal business hours.

If you want a personal copy of plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of reproduction of these copies.

Under ERISA, the people responsible for operating the plan are called fiduciaries. These individuals have an obligation to administer the plan prudently and to act in the interest of plan participants and beneficiaries. No one may discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

When you become eligible for payments from the plan, you should follow the appropriate steps for filing a claim. In case



of claim denial—in whole or in part—you will receive a written explanation of the reasons for the denial. Then, if you wish, you may request the administrator to review and reconsider your claim.

If you feel that your ERISA rights have been violated, you may file suit. Among the violations for which you may file suit are:

Improper denial of benefits.

Misuse of plan funds by a fiduciary or discrimination against you for asserting your rights. In either case, you may seek assistance from the Labor Department or file suit in a federal court.

Failure of the Plan Administrator to provide material within 30 days after receiving your written request—unless due to reasons beyond the administrator's control. If a violation exists, the court may require the Plan Administrator to provide the materials and to pay you up to $100 for each day's delay.

The court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you sued to pay these costs and fees. If you lose—or if the court finds your suit to be frivolous—you may be ordered to pay these costs and fees.

If you have any questions about your plan, please contact your supervisor or a representative of the Personnel Department. For questions regarding this explanation of your rights under ERISA, contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

WHO RUNS THE PLAN:

This plan was established and is maintained by the State Farm Mutual Automobile Insurance Company, One State

Farm Plaza, Bloomington, Illinois 61710, telephone number (309) 766-6848. In addition to the State Farm Mutual Automobile Insurance Company, the following affiliated companies also participate:

1. State Farm Life Insurance Company
2. State Farm Life and Accident Assurance Company
3. State Farm Fire and Casualty Company
4. State Farm County Mutual Insurance Company of Texas
5. State Farm General Insurance Company

This comprehensive medical plan is administered by the Plan Administrator in accordance with the applicable contracts in force under the Group Medical health plan. The State Farm Mutual Automobile Insurance Company has been designated as the Plan Administrator. James E. Rutrough, Vice President-Personnel, has been designated as agent for service of legal process. NOTE: Service of legal process may also be made upon the Plan Administrator.

The Plan Administrator shall have the power to make all reasonable rules and regulations required in the administration of the Plan and for the conduct of its affairs, to make all determinations that the Plan requires for its administration, and to construe and interpret the Plan whenever necessary to carry out its intent and purpose and to facilitate its administration. All such rules, regulations, determinations, constructions and interpretations made by the Plan Administrator shall be binding upon the Companies, all Employees, Agency Managers, Trainee Agents and their Dependents and all other interested parties.



ADDITIONAL INFORMATION:

On the preceding pages we have tried to describe the Group Medical Health Plan in easy-to-understand terms. But, if this Summary Plan Description contains any statements that disagree with the Group insurance contract or the HMO contract, the respective contracts shall govern.

In addition to the material in this Summary Plan Description, State Farm Insurance Companies file two reports with the United States Department of Labor. One is a description of the Plan called the EBS-1 Form and the other is an annual financial report. The plan description, the annual report, and any legal documents are available for review by you or your Dependents in:

1. The General Personnel Department, Corporate Headquarters, and
2. Regional Personnel Departments,

during normal business hours. Upon written request to the Personnel Department of the Regional Office or the General Personnel Group Insurance Division, State Farm Insurance Companies, Corporate Headquarters, One State Farm Plaza, Bloomington, Illinois, 61710, copies of any or all of the documents will be furnished to you at a reasonable charge. The Plan's records are maintained on a calendar year basis, ending on December 31.

For purposes of identification, the number 501 has been assigned to this comprehensive medical plan. The Internal Revenue Service has assigned State Farm Mutual Automobile Insurance Company the employer identification number 37-0533100. When writing about this plan, please identify it both by name and by the above two numbers.

State Farm Mutual Automobile Insurance Company is the underwriter for all of our plans providing medical services to State Farm associates who desire to participate in these plans by showing evidence of insurability.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE:

EMPLOYEES:

Employees who customarily work 25 hours or more a week and customarily work seven months or more a year, agency managers and trainee agents, hereinafter called "Employees," who are hired on the first day or first workday of the month are eligible on the date they are hired. Employees hired after the first workday of the month are eligible on the first day of the following month. If an Employee and spouse are both eligible for either Insurance Plan (Agents or Employees) or HMO option, either or both may be covered as an Employee/member. If either chooses not to be covered as an Employee/member, he or she may be covered as a Dependent of his/her spouse, provided the spouse is covered as an Employee/member.

a. If you apply on time, the only requirement for enrollment and consideration for coverage is the completion of an individual enrollment card. If you are hired on the first day or the first workday of the month and you enroll within your first five workdays, your coverage is effective on your date of hire. If you are hired after the first workday of the month and enroll within the month you are hired, your coverage will be effective on the first day of the month following the month in which you are hired.

b. If you do not enroll within the time limits set forth above but do enroll within-31 days of the date you are hired no medical evidence of insurability is required



and your coverage will be effective on the first day of the calendar month coincident with or next following the date you enroll.

c. IF YOU DO NOT ENROLL WITHIN 31 DAYS OF THE DATE YOU ARE HIRED, SATISFACTORY EVIDENCE OF INSURABILITY IS REQUIRED FOR YOURSELF AND EACH OF YOUR DEPENDENTS. Evidence of insurability in each case will require that the Employee completes a Declaration of Insurability form for each person to be covered. Additional medical records and/or a medical examination may be requested which must be provided at the applicant's expense. Coverage becomes effective on the first day of the calendar month coincident with or next following approval by the State Farm Mutual Automobile Insurance Company of such evidence of insurability.

d. If you waived or cancelled coverage under this Health Plan to enroll in coverage provided by another employer and lose eligibility for that coverage due to reasons other than Illness, you may be eligible for coverage under this Policy. Application must be made within 31 days of loss of eligibility under the other employer's plan or evidence of insurability will be required. All other requirements specified in this Policy must be met.

e. If you previously waived or cancelled coverage and are reassociated with State Farm within one year of your termination date you must provide evidence of insurability.

For a, b, c, d, and e above, if you are not actively at work on the date your coverage would become effective, coverage shall not become effective for you and any Dependents until the next following day on which you are

actively at work. If you and/or your Dependent(s) must furnish satisfactory evidence of insurability as a condition of becoming covered under this Health Plan and termination of membership within the eligible classes occurs without such evidence being furnished, you and/or your Dependent(s) shall continue to be subject to this requirement if you again become eligible for group medical coverage under this Health Plan or Master Policy HG00004.

Evidence of insurability is required for Employees and their Dependent(s) who previously waived or cancelled coverage offered or provided under this Health Plan or Master Policy HG00004.

Employees of agents, agency managers, and trainee agents will not be considered Employees for purposes of this definition and will not be included for coverage under this Policy.

DEPENDENTS:

Dependent means:

a. an Employee's spouse, or

b. an Employee's never married child until the end of the calendar year in which the child attains 23 years of age or the end of the calendar year in which the child becomes an Employee or agent, provided that over one-half of the child's annual support is provided by the Employee (or, in the case of a child of a divorced Employee, over one-half of the child's support is provided by his/her parents), or

c. an Employee's never married

   i stepchild (as long as the natural parent is covered under the plan) residing with the Employee more than six months of a calendar year



   ii. foster child residing 365 days per year with the Employee who is the court appointed legal guardian and who claims the child as a dependent for federal income tax purposes, or

   iii. a legally adopted child (Note: a child who is in the custody of the Employee, pursuant to a petition for adoption filed with a court of competent jurisdiction)

   until the end of the calendar year in which the child attains 23 years of age or the end of the calendar year in which the child becomes an Employee or Member, provided that over one-half of the child's annual support is provided by the Employee (or, in the case of a child of a divorced Employee, over one-half of the child's suppport is provided by his/her parents), or

d. an Employee's never married child who has attained age 23 while the child is

   i. mentally or physically incapable of earning his/her own living,

   ii. actually receiving over one-half of his/her annual support from the Employee (or, in the case of a child of a divorced Employee, receiving over one-half of his/her support from his/her parents), and

   iii. covered hereunder on the date immediately preceding the day insurance otherwise would have been terminated due to age.

Eligibility:

a. If you have one or more Dependents when you become eligible for participation in this Health Plan and you enroll yourself and Dependents on or prior to

this date, your Dependents will be covered when your coverage becomes effective,

b. If you do not enroll your Dependents when you become eligible for participation in this Health Plan but do so within 31 days of that date, your Dependents will become covered on the first day of the calendar month coincident with or next following the date of your application for Dependent coverage.

c. If you fail to enroll your Dependents within 31 days of the date you first become eligible for Dependents' coverage, evidence of insurability will be required and coverage will not become effective until the first day of the calendar month coincident with or next following approval of such evidence of insurability.

d. If your Dependents for whom coverage was waived or cancelled under this Health Plan enroll in coverage provided by another employer and later lose eligibility for this coverage due to reasons other than Illness, they may be eligible for coverage under this Health Plan if you are covered under this Health Plan. Application must be made within 31 days of loss of eligibility under the other employer's plan or evidence of insurability will be required. All other requirements specified in this Policy must be met.

e. If you previously waived or cancelled coverage and are reassociated with State Farm within one year of your employment termination date, your dependents must provide evidence of insurability.

Once you are enrolled for Dependents' coverage, newly acquired Dependents will be covered on the date acquired if written notification is provided and any required premium is paid.



If you are not enrolled for Dependents' coverage, newly acquired Dependents will be covered on the date acquired if written notification is provided within 31 days of the date acquired and any required premium is paid.

If your Dependent is confined in a Hospital on the date you otherwise become covered for Dependents' coverage with respect to such Dependent, that Dependent will not become covered until the day following the Dependent's final discharge from the Hospital.

Written notice to the Personnel Department is required to cover a Dependent subsequent to your effective date.

Dependent children are eligible for coverage under only one option whether under an HMO or Master Policy HG00003 or Master Policy HG00004. A Dependent child cannot be covered concurrently by more than one Employee under this policy.

Note: Any person covered as an Insured or Insured Dependent under Master Policy HG00004 is not eligible simultaneously for coverage in either capacity under Master Policy HG00003 or an HMO.

CHANGE IN MARITAL OR DEPENDENT STATUS

Regardless of the medical option you have chosen, if a change should occur in your marital status or dependent status, be sure to notify your supervisor and Group Insurance Specialist.

## SECTION II - GROUP MEDICAL INSURANCE

### CERTIFICATE OF COVERAGE

THE STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY (hereafter called the Insurer), Bloomington, Illinois, hereby certifies that the holder of this

certificate is insured under and subject to the terms and conditions contained in Master Policy No. HG00003 issued to:

**STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY**
**and its Subsidiaries and Affiliates**

(hereafter called the Policyholder) while he/she is within the classes eligible for insurance thereunder provided application has been made and accepted and that the necessary contributions are made toward premiums for such insurance.

COMPREHENSIVE MEDICAL PROVISIONS:

Comprehensive Medical Expense Benefits provide payment of Eligible Charges up to a maximum as shown below:

MAXIMUM BENEFIT:

| Classification | Maximum |
|---|---|
| All Eligible Employees | 1,000,000 |
| Their Dependents | 1,000,000 |

Note:

(1) The Comprehensive Medical Maximum was increased from $250,000 to $ 1,000,000 effective January 1, 1983. However, the increased maximum did not apply to any insured individual who was hospital confined on January 1, 1983 and will not apply to such person unless and until he/she is finally discharged from hospitalization.

(2) As of January 1, 1983, the remaining Maximum Benefit is $1,000,000 reduced by the amount of benefits paid, if any, under Master Policies G-5989 and G-637A.



DEDUCTIBLE:

The individual deductible applies to the Eligible Charges of each calendar year, but it only applies once for you, and only once for each Dependent, in any calendar year regardless of the number of illnesses. However, when members of a family have incurred Eligible Charges that satisfy the family deductible amount during a calendar year, no further deductible is required in connection with any member of that family.

The deductible applies to all Illness charges, including inpatient nursery charges for well-baby care of a newborn infant. The deductible does not apply to eligible preventative diagnostic tests and procedures as outlined in Benefit #28. (See page 4290)

The deductible amounts are as follows:

Plan A — $100 individual/$300 family

Plan B — $250 individual/$500 family

Plan C — $500 individual/$1000 family

COINSURANCE:

After satisfying the Deductible, Comprehensive Medical Expense Benefits provide payment as follows:

(a) Individual

Option A — 80% of the first $2000 of Eligible Charges

Option B — 80% of the first $5000 of Eligible Charges

Option C — 75% of the first $8000 of Eligible Charges

Family

Option A — 80% of the first $2,000 of Eligible Charges for each insured Individual

Option B — 80% of the first $10,000 of Eligible Charges

Option C — 75% of the first $16,000 of Eligible Charges

(b) 100% of the first $40 of each charge for treatment of Mental or Nervous Disorders or psychoanalytic care, rendered other than while the patient is confined to a Hospital as a registered bed patient, subject to the other limitations herein. (see page 4215.)

(c) 100% of the first $20 of each charge for certain types of care of distortions, misalignment or subluxation of, or in the vertebral column unless such services are rendered during general anesthesia, during a cutting operation or while the patient is confined in a Hospital. (see page 4220).

(d) 100% of the first $40 per Visit (maximum of five Visits) for bereavement counseling rendered as part of a Hospice care program (see page 4270).

(e) 100% of the charges for a second (and third) surgical opinion and associated ancillary diagnostic services performed by a Board Certified Specialist other than the Physician who recommended the surgery.

(f) 100% of the first $50 per Home Health Care Visit subject to a maximum payment of $5,000 per calendar year (see page 4260).

(g) After satisfaction of the co-payment amount in (a) above or a combination of (a) through (f) above, in any calendar year, any subsequent eligible charges



incurred in such calendar year are payable at 1 00% except as noted in (h) below.

(h) Charges for the care or treatment of alcohol abuse, drug abuse, or Mental or Nervous Disorders are payable at 80% fcr Options A & B and 75% for Option C except that certam charges for outpatient care of mental or nervous conditions are payable at 1 00% as set forth in items (b) and (d) above.

BENEFIT PERIOD:

A Benefit Period is a calendar year or that portion of a calendar year during which you or your Dependent is insured under this Master Policy. All Eligible Charges incurred during a Benefit Period for all Illnesses are used in computing benefit payments.

A Benefit Period terminates on the last day of the calendar year, the last day of the month in which you or your Dependent otherwise ceases to be eligible for insurance, or the day the Maximum Benefit is reached, whichever occurs first.

Calendar years shall begin on January 1 and end on December 31 of the same year.

MAXIMUM BENEFIT:

The maximum benefit is a lifetime aggregate payment for all Illnesses. However, a person who has received payment for all or a part of the maximum benefit may be reinstated for the full maximum benefit upon approval of evidence of insurability satisfactory to the Insurer.

On January 1 of every year, the balance of your (or your Dependent's) maximum benefit remaining shall be automatically increased $2,500 without evidence of insurability or the amount necessary to bring that balance

to the full maximum benefit, whichever is the lesser amount.

PREMIUMS SHARED:

The premiums for this insurance are shared by the Employee and the Policyholder. Your share of the premium may be paid with pre-tax (Flexible Compensation) dollars according to the terms of the State Farm Insurance Companies Flexible Compensation Plan for U.S. Employees, or with after-tax dollars deducted from your paycheck.

The premium charged for this Master Policy is essentially the cost of benefits provided plus the cost of administration. Nevertheless, depending upon underwriting results from year to year, the premium charged may result in income to the Insurer. If in any calendar year the aggregate income to the Insurer as a result of this Master Policy is in excess of the Policyholder's share of the aggregate cost, an amount equal to such excess shall be applied by the Policyholder for the sole benefit of the Employees.

PLEASE NOTE:

This certificate is a brief description of your coverage—all terms and conditions governing your coverage are contained in the Master Policy issued to your employer—you are covered if you are eligible, have properly enrolled in the plan, and are making your necessary payments toward the premium.

The Master Policy may be amended or altered at any time by written agreement between the Policyholder and Insurer without your or your Dependents' consent.

If you or your Dependents leaye the plan for any reason while continuing to be eligible, reenrollment at a later



date will be subject to satisfactory medical evidence of insurability and coverage may be denied.

If you have questions about the coverage for which you are eligible or the benefits provided, contact your supervisor or the Group Insurance Benefits Specialist.

DEFINITIONS:

The following words and phrases shall have the stated meanings when used in these provisions for Comprehensive Medical Expense Benefits. Additional terms are defined in the Master Policy which is available for review by request to the Personnel Depar'ment.

COSMETIC SURGERY:

The surgical alteration of tissue for the improvement of the insured individual's appearance rather than improvement or restoration of bodily function.

CUSTODIAL CARE:

Those services for personal, family or domestic needs that are primarily designed to assist with the activities of daily living. This care could be provided by persons without professional skills or training. Custodial care includes, but is not limited to, help in walking, assistance with bathing, dressing, and eating.

DEVELOPMENTAL DISORDERS:

Developmental Disorders mean disorders that are characterized by or whose manifestations include delays in development of specific academic, language, speech and motor skills but are not due to specific, identifiable, physical or neurological disorders.

DURABLE MEDICAL EQUIPMENT:

Equipment which

a. can withstand repeated use,

b. is primarily and customarily used to serve a medical purpose,

c. generally is not useful to a person in the abs~nce of Illness, and

d. is appropriate for use in the home.

ELIGIBLE CHARGES:

Those charges incurred by an insured individual

a. as a result of an Illness for which the insured individual is not entitled to benefits under any Workers' Compensation or Occupational Disease law,

b. which are Necessary Treatment of an illness,

c. are not in excess of the Reasonable and Customary Charge for the services performed or the materials furnished, and

d. with respect to Medicare participants, are not in excess of the balance billing limit for charges allowed by Medicare on physician fees incurred by Medicare participants.

HOME HEALTH CARE:

A formal program of part-time or intermittent care and treatment for an Illness which is performed in the home of an insured individual. It must be provided by a Hospital or home health service or agency and must:

a. be established and operated in accordance with the applicable laws in the jurisdiction in which it is



located and, where licensing is required, be licensed and approved by the regulatory authority having responsibility for licensing under the law,

b. be under the direct supervision of a Physician,

c. be coordinated by a graduate registered nurse (R.N.), and

d. maintain medical records on each patient.

HOSPICE:

An agency that provides a coordinated program of home and inpatient care for the special physical, psychological, and social needs of terminally ill persons and their families. A terminally ill person is one who has been diagnosed by a Physician as having a life expectancy of six months or less. The hospice agency must:

a. be established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, be licensed and approved by the regulatory authority having responsibility for licensing under the law,

b. be under the direct supervision of a Physician,

c. be coordinated by a graduate registered nurse (R.N.),

d. provide continuous 24-hour nursing service, and

e. maintain medical records on each patient.

HOSPITAL:

Hospital means a legally operated institution having accommodations for the care and treatment of sick or injured resident inpatients which is:

a. licensed as a hospital under the Hospital Licensing Laws of the state in which it is situated; or

b. accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

This definition shall not include any institution operating as a clinic, nursing home, rest home, home for the aged, convalescent home, group home, half-way house, residential treatment facility or similar establishment.

ILLNESS:

A bodily disorder or disease, Mental or Nervous Disorder, pregnancy or accidental bodily injury. In addition, charges for well-baby nursery care will be considered on the same basis as charges incurred in connection with an "illness." With respect to the transplant of a natural organ or organs or other natural tissue from one living person to another, the medical expense of the donor will be considered as Eligible Charges for an illness of the donor.

MENTAL OR NERVOUS DISORDER:

Mental or Nervous Disorder means a neurosis, psychoneurosis, psychopathy, psychosis or other mental, behavioral, or emotional disease, disturbance, or disorder of any kind regardless of the cause or origin, including, but not limited to autism and affective mood disorders.

NATIONAL SCIENTIFIC ORGANIZATION:

An entity composed of medical specialists recognized by the American Medical Association or the Council on Medical Specialty Societies that evaluate diagnostic and therapeutic procedures to determine whether such procedures are clinically acceptable.

NECESSARY TREATMENT:

The treatment.

a. must be recommended by a Physician;



b. must be commonly and customarily recognized throughout the Physician's profession and within the United States as appropriate in the treatment of the patient's diagnosed Illness; and

c. determined to be of proven effectiveness by the appropriate National Scientific Organization related to the diagnosed Illness.

In the case of Hospital confinement, on an inpatient or outpatient basis, the length of confinement and medical services and supplies furnished by the Hospital will be considered "necessary treatment" only to the extent they are determined by the Insurer to be related to the treatment of the diagnosed Illness.

PARTIAL HOSPITAL PROGRAM

A program which provides an integrated and comprehensive schedule of recognized psychiatric treatment under the direct supervision of a Physician. The "partial hospitalization program" must be:

a. part of a Hospital complex, a component of a community mental health center, or a "free-standing" unit and

b. established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, be licensed and approved by the regulatory authority having responsibility for licensing under the law.

PHYSICIAN:

A licensed practitioner of the healing arts performing services within the scope of his/her license as provided by the laws of the state in which these services are performed.

PRE-EXISTING ILLNESS(ES):

An Illness for which medical advice or treatment was recommended by, received from or diagnosed by a Physician within 3 months prior to the effective date of coverage of the insured individual.

REASONABLE AND CUSTOMARY CHARGE:

Reasonable and Customary Charge means, with respect to fees charged by a Physician or by a provider of professional services, medicines, or supplies, the most common charge, in the absence of insurance, for similar professional services, medicines, or supplies within the geographic area where the service, medicine, or supply was actually provided, so long as that charge is reasonable. Geographic area means the municipality (or, in the case of a large city, the subdivision thereof) in which the service, medicine, or supply is actually provided or a greater area if necessary to obtain a representative cross-section of charges for a similar service, medicine, or supply. Reasonable and customary charges will be determined, in good faith, by the Insurer.

In determining whether a charge is reasonable and customary, one or more of the following factors may be considered:

a. the level of skill, extent of training, and experience required to perform the procedure or service;

b. the length of time required to perform the procedure or service as compared to the length of time required to perform other similar procedures or services;

c. the severity or nature of the illness or injury being treated;

d. the cost to the provider of providing the service or performing the procedure;



e. the cost and availability of alternative modes of treatment; and

f. such other factors, in the reasonable exercise of discretion, which are determined to be appropriate.

The following limits apply to multiple surgical operations:

a. When multiple or bilateral procedures, which add significant time or complexity to patient care, are performed at the same operative session, the maximum limit for the procedures shall be the Reasonable and Customary Charge for the primary procedure plus 50% of the Reasonable and Customary Charge for the secondary procedure.

b. When an incidental procedure (e.g. incidental appendectomy, lysis of adhesions, excision of previous scar) is performed at the same operative session, the Reasonable and Customary Charge will be that of the primary procedure only.

c. When an inherent procedure is performed at the same operative session, the Reasonable and Customary Charge will be that of the primary procedure only.

REASONABLE AND CUSTOMARY CHARGE EXAMPLES

The Group Medical Plan provides coverage for eligible procedures up to an amount that is considered reasonable and customary (R&C). State Farm uses data gathered every six months representing the actual fees charged by medical providers for specific procedures. Since charges for the same procedure may vary by area of the country, we use data from the specific geographic location where the procedure is performed. This statistical data is ranked into percentiles. State Farm uses the 90th percentile

amount which means that 90% of the reported charges are at or below this amount. In addition, State Farm adds a 5% administrative allowance to this figure. (See page 4180 for definition of Reasonable and Customary.)

EXAMPLE 1:

Let's look at removal of a gallbladder performed in the Waco, Texas area. Reviewing the statistics available, we determine that 163 of these procedures have been performed. Charges ranged from $ 1,150 to $ 1,700. The average charge was $ 1,013 . The 90th percentile figure is $1,525. When we add the administrative allowance, the Reasonable and Customary allowance is $1,605. The Group Medical Plan will, therefore, pay no more than this amount for a removal of a gallbladder in their geographic location.

EXAMPLE 2:

When a surgeon performs more than one procedure during the operative session, it is a common billing practice in the medical community to reduce the charge for any second and subsequent procedures. State Farm administers the reasonable and customary provision in accordance with this practice by allowing one-half of the actual R&C amount determined for each of the subsequent procedures. For example, at one operative session a patient has a vaginal delivery and a tubal ligation. The reasonable and customary allowance for the vaginal delivery is $1,890 and $960 for the tubal ligation. By considering one-half of the normal allowance for the tubal ligation, the total payment is $2,370 ($1,890+ ½ of $960 or $480).



EXAMPLE 3:

The American Medical Association establishes procedure codes for most surgical procedures in order to provide uniformity in coding practices. Some codes include procedures that are considered "inherent" or "incidental." Because these procedures add little to the difficulty or complexity of the primary surgery, it is appropriate to allow the reasonable and customary amount for the primary procedure only. No additional allowance for the "inherent" or "incidental" procedures would be appropriate. For example, a patient has a hysterectomy performed. When she received the bill, it was coded as follows:

| Code | Procedure | Charge |
|---|---|---|
| 58150 | Total Hysterectomy | $1,300 |
| 58720 | Removal of ovaries/tubes | 950 |
| 49000 | Exploration of abdomen | 671 |
| 44955 | Appendectomy | 250 |
| 58740 | Removal of adhesions | 550 |
| | Total Charge | $3,721 |

By definition, code 58150, Total Hysterectomy, includes removal of ovaries, tubes, exploration of the abdomen and removal of adhesions. The appendectomy is considered "incidental". Therefore no charge should have been made for it. If this claim had been appropriately coded, using 58150 and 44955, the charge would be $1,300 for the total hysterectomy and no charge for the appendectomy.

REHABILITATION FACILITY:

A legally operated institution that provides coordinated multidisciplinary physical restorative services for the care and treatment of sick or injured resident inpatients which is:

a. established and operated in accordance with the applicable laws of the state in which it is situated; and

b. accredited by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities.

This definition shall not include any institution including a rehabilitation facility or any part of a rehabilitation facility operated primarily as a clinic, nursing home, rest home, home for the aged, convalescent home, group home, half-way house, residential treatment facility or similar establishment.

RESPITE CARE:

A short term inpatient stay which may be necessary for the Hospice care patient in order to give temporary relief to the person who regularly assists with home care.

ROOM AND BOARD CHARGES:

Charges made by a Hospital or Skilled Nursing Facility for the cost of the room, meals and services (such as general nursing services) that are routinely provided to all inpatients.

SKILL NURSING FACILITY:

An institution which is approved as such by Medicare.

TOTAL DISABILITY AND TOTALLY DISABLED:

The inability to engage, as a result of Illness, in the Employee's normal occupation with the employer, provided the Employee is not engaged in any occupation or business for wage or profit, and with respect to a Dependent, the inability to perform the usual and



customary duties or activities of a person in good health and of the same age and sex.

VISIT:

Each personal attendance of a Physician to the patient, regardless of the type of professional services rendered, whether it might be otherwise termed consultation, treatment, or given some other name.

BENEFITS:

Benefits are payable if an insured individual incurs Eligible Charges during a Benefit Period which exceed the Deductible amount. However, in no event shall any expense be payable under more than one of the benefits described below.

The charge for a service or a purchase shall be deemed to be incurred on the date the service is performed or the purchase is made.

Expenses incurred for the following will be considered Eligible Charges:

1. Room and Board Charges and routine nursing services for confinement in a Hospital or Rehabilitation Facility, excluding any private room charge in excess of the most common semiprivate room, unless the private room is considered Necessary Treatment. If the Hospital or Rehabilitation Facility does not have semiprivate rooms, its lowest private room charge will be considered eligible;

2. Semiprivate room and board and routine nursing services for confinement in a Skilled Nursing Facility (which is approved as such by Medicare) up to a maximum of 100 days confinement in each Benefit

Period; provided that the confinement is not for routine Custodial Care and that the patient is personally visited at least once every 30 days by his/her Physician. The benefit is reduced by the amount, if any, which is paid on payable for such confinement by Medicare. A Benefit Period means any one continuous period of confinement, whether due to one or more causes, and all successive periods of confinement due to the same or related cause or causes. A successive confinement will be considered as a new confinement, regardless of its cause, if it occurs after a period of 60 days or longer during which the individual has neither been confined in a Hospital nor a Skilled Nursing Facility;

3. Charges for confinement and/or care of alcoholism and/or drug abuse provided the facility furnishing such care is accredited by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities;

4. Charges by a Hospital for medical services and supplies;

5. Anesthetics and their administration;

6. Fees of Physicians and surgeons for medical care, treatment and surgical operations rendered by and in the physical presence of the doctor, except that:

   a. The maximum Eligible Charges for treatment of Mental or Nervous Disorders or psychoanalytic care for any reason rendered by a Physician or a social worker uponthe referral of a Physician during a Visit by or to the patient will not exceed;

      i. $40 for each such Visit,

      ii. one Visit on any one day, and



      iii. 50 Visits during any calendar year.

      The charges for treatment rendered by a social worker are Eligible Charges when the social worker is licensed or registered by the state in which these services are performed or is certified by the National Academy of Certified Social Workers.

      This limitation is not applicable while the patient is confined as a resident in-patient in a Hospital;

   b. Charges for care in connection with the detection and correction by manual or mechanical means (including the application of treatment modalities such as, but not limited to diathermy, ultra-sound, heat and cold, etc.) of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column are limited to:

      i. a payment of $20 for each Visit,

      ii. one Visit on any one day, and

      iii. 50 Visits during any calendar year.

      This limitation is not applicable if such services are rendered during general anesthesia, or during a cutting operation or while the patient is confined in a Hospital;

7. Services provided by a licensed physiotherapist at the direction of a Physician;

8. Fees for X-ray examinations (other than dental), microscopic and laboratory tests and other diagnostic services;

9. Fees for X-ray or radiation therapy;

10. Charges for necessary transportation of the individual by professional ambulance services, and when medically necessary, railroad or regularly scheduled airline to, and returning from, a Hospital or sanatoriurn equipped to furnish treatment for the Illness (limited to transportation within the continental U.S. and Canada).

    a. Transportation will be considered to be "necessary" transportation if it is due to emergency need or recommended by a Physician for the well-being of the patient, to the *nearest* Hospital equipped to render the necessary care. Necessary transportation does not include a mode of transportation selected solely for the convenience of the patient.

    b. In case of transfer from one Hospital to another, transportation charges will be eligible only if the transfer is medically necessary and because the Hospital from which the patient is being transferred lacks the facilities necessary to treat the patient. Again, only transportation to the *nearest* Hospital capable of treating the patient will be eligible for payment.

    c. Transportation charges to a Hospital for outpatient treatment will be eligible for payment only if such transportation is in connection with an emergency need related to an injury or Illness;

11. Medical supplies if prescribed by a Physician as follows:

    a. blood and other fluids (except insulin and associated syringes) to be injected into the circulatory system,



    b. artificial limbs and eyes for loss of natural limbs and eyes which occurred while insured,

    c. lens (contact or frames) for each eye immediately following and because of cataract surgery when required for protective rather than refractive purposes,

    d. casts, splints, trusses, braces, crutches and surgical dressings, and colostomy supplies,

    e. orthotic devices designed for a specific individual, stump socks, corrective orspecial shoes attached to a brace,

    f. rental of Durable Medical Equipment which satisfies all of the criteria as defined on page 4155. The Insurer also will consider as eligible all charges for supplies, materials and repairs necessary for the proper operation of such equipment and also Reasonable and Customary Charges and necessary expenses for the training of a person to operate and maintain the equipment for the sole benefit of the patient,

    g. rental of Durable Medical Equipment for kidney dialysis for the personal and exclusive use of the patient, so long as dialysis treatment continues to be medically required. The Insurer also will consider as eligible all charges for supplies, materials and repairs necessary for the proper operation of such equipment and also Reasonable and Customary Charges and necessary expenses for the training of a person to operate and maintain the equipment for the sole benefit of the patient;

    h. drugs and medicines which require a written prescription of a Physician, are dispensed by a

licensed pharmacist or Physician and are specifically supplied and billed by a Home Health Care program.

12. Charges by a Physician or qualified speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to an Illness, or to surgery on account of an illness;

13. a. Charges for the treatment of teeth, gums or alveolar process, or for dental appliances or supplies used in such treatment for Employees, Agency Managers, Trainee Agents, Retired Employees and Agency Managers who have continued their State Farm Dental Plan after retirement, and their Dependents, EXCEPT these charges are specifically limited to the following:

1) Hospital and surgicenter expenses.

2) Expenses incurred while insured as a result of and within 24 months after an accident suffered while insured hereunder for treatment of injury to natural teeth, including the replacement of such teeth or setting of a jaw fractured or dislocated in such accident. No benefits are payable for any accident occuring entirely within the mouth.

The time period for dental accidents for children under age 16 may be extended beyond 24 months provided the dentist presents a treatment plan within 24 months following the accident. The extension of dental accident benefits for these children will not be provided for any accident occurring entirely within the mouth. Benefits will be payable only if the child is insured on the date



service is finally rendered. The extension of benefits beyond 24 months will not apply to any individual whose accident occurs on or after the attainment of age 16.

3) Treatment of active periodontal disease, except:

i. periodontal maintenance procedures (periodontal prophylaxis);

ii. periodontal root scaling/planing;

iii. surgical extraction of the teeth; or

iv. osseous surgery.

13. b. Charges for the treatment of teeth, gums, or alveolar process, or for dental appliances or supplies used in such treatment for Retired Employees, Retired Agency Managers and their Dependents, except those who continued their State Farm Group Dental Plan after retirement, are specifically limited to the following:

1) Hospital and surgicenter expenses.

2) Expenses incurred, as a result of and within 24 months after an accident suffered while insured hereunder, for treatment of injury to natural teeth including the replacement of such teeth or setting of a jaw fracture or dislocation.

If such an accident results in damage to false teeth, in addition to injury to natural teeth, as a result of and within 24 months of said accident, expenses for treatment of damage to false teeth are also eligible charges.

The time period for dental accidents for children under age 16 may be extended beyond 24 months provided the dentist presents a treatment plan within 24 months following the accident. The extension of dental accident benefits for these children will not be provided for any accident occurring entirely within the mouth. Benefits will be payable only if the child is insured on the date service is finally rendered. The extension of benefits beyond 24 months will not apply to any individual whose accident occurs on or after the attainment of age 16.

3) Treatment of active periodontal disease, except:

i. periodontal maintenance procedures (periodontal prophylaxis); or

ii. surgical extraction of teeth.

4) Surgical removal of impacted teeth.

5) Treatment resulting from cancerous growths or osteomylitis.

14. Charges for diagnosis, treatment and care of temporomandibular joint dysfunction except by dentures including full or partial plates or bridgework whether permanent or removable. The maximum payment is limited to $2,000 in an individual's lifetime.

This limitation is not applicable to expenses incurred at a Hospital or Surgicenter.

15. Charges for the implantation or injection following surgical removal of all or a portion of the breast made necessary by infection or disease and subsequent



implantation or injections which result from infection or disease provided the initial implantation or injection was made necessary by infection or disease.

16. Charges for, or in connection with, reconstructive or Cosmetic Surgery when the surgery is the result of an accident suffered while insured hereunder. Charges for Cosmetic Surgery due to congenital defects for a child under age 10 will also be considered as Eligible Charges.

17. Charges

a. for confinement in a Christian Science sanatorium only with respect to those guests who are admitted for healing (not for rest or study) and who are under the care of an authorized practitioner. All charges by such sanatoria shall be deemed Hospital Room and Board Charges,

b. for services rendered by a Christian Science practitioner in the physical presence of a person and given in accordance with the healing practices of Christian Science, and

c. for professional nursing services rendered by a Christian Science nurse in accordance with the healing practices of Christian Science;

18. a. Services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for full-time, private duty nursing services rendered to an individual who is confined to a Hospital as a registered bed patient.

b. Charges for full-time, private duty nursing services rendered to an individual who is not confined to a Hospital as a registered bed patient are limited to a maximum payment of $5,000 per calendar year.

A Physician must prescribe these services and certify that the services:

i. are being provided in lieu of Hospital confinement,

ii. cannot be provided through intermittent home nursing Visits, and

iii. cannot be provided by non-professional personnel such as an attendant, aide or the patient's family members,

19. Charges for Home Health Care rendered to an insured individual. Charges for such care are limited ma maximum of $50 per Home Health Care Visit and a maximum payment of $5,000 per calendar year.

The Home Health Care program must be prescribed by a Physician. The Physician must certify that the insured individual would otherwise have been confined in a Hospital or Skilled Nursing Facility.

For the purpose of this benefit, each Visit by a member of a Home Health Care team shall be considered as one Home Health Care Visit and four hours of home health aide service shall be considered as one Home Health Care Visit.

No benefits are payable for Home Health Care charges incurred for:

a. services of a person who ordinarily resides in the insured individual's home or who is a member of such individual's family,

b. Custodial Care,

c. transportation services,

d. any period during which the insured individual is not under the continuing care of a Physician,



e. full-time, private duty nursing services,

f. homemaker services, or

g. meals delivered to the home.

Coverage under this Home Health Care benefit is also subject to the other exclusions, exceptions and limitations of this plan.

20. Charges for Hospice care rendered to an insured individual. However, charges for:

a. care rendered to an individual not confined in a Hospital or Hospice facility as a registered bed patient are limited to a maximum lifetime payment of $5,000.

b. inpatient Respite Care are limited to a maximum of five days per confinement.

c. bereavement counseling are limited to a maximum of five visits and $40 per Visit per insured individual. Such counseling may occur before but no later than three months following the death of the individual who received Hospice care. Bereavement counseling will be considered an Eligible Charge if incurred by family members insured under this Master Policy.

No benefits are payable for Hospice charges incurred for:

a. Custodial Care,

b. financial and legal planning,

c. funeral arrangements,

d. homemaker services,

e. services rendered by volunteers or individuals who do not regularly charge for their services,

f. services rendered by a licensed pastoral counselor to a member of his/her congregation unless the pastoral counselor is an employee of the Hospice agency rendering such services, or

g. the time period after the insured individual's death, except for bereavement counseling.

Coverage under this Hospice Care benefit is also subject to the other exclusions, exceptions and limitations of this plan;

21. Charges for a second surgical opinion and associated ancillary diagnostic services performed by a Board Certified Specialist other than the Physician who recommended the surgery or who is associated with the Physician who recommended the surgery. Charges for a third opinion will be considered an Eligible Charge if the second opinion indicates that surgery is not medically advisable. If the Physician certifies that a second (or third) surgical opinion was rendered, the Benefit Percentage for the second (and third) surgical opinion and associated ancillary diagnostic services will be 100%;

22. Charges for the educational or instructional care provided to an insured individual for the purpose of self-care, administration, and management of such insured individual's diabetic condition up to a $100 lifetime maximum;

23. Charges for testing of a prospective organ donor who is an insured individual.

    Charges for testing of prospective organ donors who are immediate family members of the recipient, provided the recipient is an insured individual. Immediate family members mean the recipient's



spouse, father, mother, brothers, sisters, sons and/or daughters.

In addition, a lifetime limitation of $2,000 is provided for such charges incurred, regardless of the number of individuals tested, for other than immediate family members provided the recipient is an insured individual;

24. Medical services and supplies furnished by a Rehabilitation Facility;

25. Charges for treatment of Mental or Nervous Disorders provided in a Partial Hospitalization Program. Coverage is limited to 100 days of care per calendar year. The treatment must be provided (a) as a transition from, or an alternative to, inpatient hospitalization, (b) on a planned and regularly scheduled basis and (c) involve a minimum of three hours of care in any one day (which will be considered as a day of care). This benefit is not applicable when the patient is confined overnight as a resident inpatient;

26. Charges for investigational or experimental procedures and treatment only if all the following criteria are met.

    a. The Physician must certify that accepted medical procedures have proven to be ineffective in the treatment of the diagnosed condition and that the condition, if not treated through investigational or experimental means, would be life threatening. Accepted medical procedures are those treatment modalities which meet the definition of Necessary Treatment.

    b. The investigational or experimental treatment must be performed at a facility which has been

designated by the appropriate Federal regulatory body to perform the procedure.

c. The investigational or experimental treatment must be under an active investigative protocol. Procedures which have been determined to be unproven following an investigative protocol will not be eligible for payment.

d. The expenses must not have been reimbursed, or be eligible for reimbursement, under any state or Federal grant, study, fund, endowment or other public or private funding mechanism.

If the above criteria are met the investigational or experimental treatment will be eligible subject to all other policy provisions and a maximum lifetime benefit of $250,000 per individual;

27. Charges for well-baby care services rendered by a Physician during the first 24 months of an Individual's life. Well-baby care includes, but is not limited to, regularly scheduled check-ups, immunizations, laboratory tests and other associated screening or diagnostic services that occur subsequent to the Individual's initial Hospital confinement at birth. The Benefit Percentage for well-baby care services will be 100% and will not be subject to the Deductible. This benefit is limited to $100 per calendar year per Individual.

28. Charges for preventive diagnostic tests and procedures listed below:

    a. Screening Mammography

    Individual age 35-39: one baseline mammogram during these years



Individual age 40-49: one mammogram every other year

Individual age 50 and over: one mammogram every year

b. Serum Cholesterol Test

One test per individual per year

c. Resting Electrocardi9gram (EKG)

Individual age 35-39: one baseline EKG during these years

Individual age 40-49: one EKG every other year

Individual age 50 and over: one EKG every year

d. Tetanus Immunization

e. Influenza Immunization

f. Papanicolaou Test (Pap Smear cervical or vaginal only)

One test per individual per year

g. Fecal Occult Blood Test

One test per individual per year

Reimbursement of any Physician's office charge performed in association with the preventive diagnostic test(s) or procedure(s) listed above will be limited to a maximum of $30.

The above services will be covered at 100% and will not be subject to the Deductible.

OUTPATIENT PRESCRIPTION DRUG EXPENSE BENEFIT:

Charges for outpatient drugs and medicines (including insulin and associated syringes (which require a written

prescription of a Physician and which must be dispensed by a licensed pharmacist or Physician will be considered for reimbursement. However, reimbursement for these charges will be administered under an agreement with Medco Containment Services, Inc. as follows:

1. Prescription Drug Card Option

   Upon submission of the written prescription and Paid Prescriptions ID card to a Participating Pharmacy, the insured Individual will be responsible for a $7.00 copayment per name brand prescription or refill (maximum 30 day supply) or $400 copayment per generic prescription or refill (maximum 30 day supply). No other deductible or copayment will apply.

   Participating Pharmacy means a pharmacy recognized as a Participating Pharmacy under the agreement with Medco Containment Services, Inc.

   Expenses incurred at non-Participating Pharmacies or at Participating Pharmacies when the Prescription Drug Card is not used will be reimbursed under the basic pricing formula used by Paid Prescriptions, Inc. to reimburse Participating Pharmacies. The basic pricing formula is the average wholesale price plus a dispensing fee plus an administrative fee. The insured Individual will have to pay any charges above this amount plus the $7.00 or $4.00 copayment amount.

2. Mail-order Option

   Upon submission of the written prescription to National RX Services, Inc. the insured Individual will be responsible for a $3.00 copayment per prescription or refill (maximum 90 day supply). No other deductible or copayment will apply.

3. Prescription drugs covered under this program are:



- all Federal Legend drugs
- all state restricted drugs
- compound medications which contain at least one Federal Legend drug
- insulin with or without a prescription (NOTE: Mail Service requires a prescriplion)
- insulin syringes (NOTE: Mail Service requires a prescription)
- syringes unless specifically excluded below

4. Prescription drugs not covered under this program are:

- birth control pills, diaphragms, jellies, ointments, foams, condoms and other birth control devices regardless of intend-ed use.
- smoking deterrents
- all over-the-counter (non-prescription) drugs except insulin
- therapeutic devices/appliances
- investigational/experimental drugs
- drugs whose primary use is to stimulate hair growth
- anorexients/amphetamines
- medications for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medications furnished by any other drug or medical service for which no charge is made to the member

- diabetic supplies such as lancets, autolet, sugar test tablets, etc.*
- allergy serum*
- allergy syringes*
- drugs provided by a Home Health Care Agency*

*These items are eligible for consideration under the Group Insurance Option and should be submitted with the standard claim form to State Farm.

For the purpose of this provision, the Annual Deductible, Coinsurance, Benefit Period, Maximum Benefit, Pre-Existing Conditions, and Coordination of Benefits provisions are not applicable. In no event will benefits be payable under both this provision and any other plan Benefits. All other Group Insurance option provisions apply to this benefit.

UTILIZATION REVIEW:

Hospital admissions and length of Hospital stays are subject to review by a professional review organization designated by the Insurer.

1. Pre-Admission Notification Requirements

   It is the responsibility of the insured Individual or his/her family to notify such organization:

   a) prior to admission to a Hospital for non-emergencies; or

   b) within 2 business days following an emergency admission to a hospital.

2. Effect on Benefits

   If the professional review organization is not notified in accordance with the requirements stated above, any Hospital charges that are otherwise Eligible



Charges will be reduced by $300. The remaining eligible Charges will be subject to the Deductible and co-payment amount.

3. Limitations

   a) Notification to the professional review organization is not required when Medicare is primary.

   b) Notification to the professional review organization pursuant to the requirements stated above does not guarantee payment of any charges in connection with the Hospital admission. Such charges are subject to all other policy provisions, exclusions, exceptions and limitations.

INELIGIBLE CHARGES:

All charges Not Specifically Listed in the Benefits section, including:

1. Charges as a result of any Illness which arise out of or in the course of any employment for which the individual is entitled to or eligible to receive benefits under any Workers' Compensation or Occupational Disease law, or receives any settlement from a Workers' Compensation carrier;
2. Charges due to war or any act of war, whether declared or undeclared;
3. Charges incurred when the individual is not under the direct care of a Physician;
4. Charges which the individual is not legally obligated to pay;
5. Charges which are in excess of the Reasonable and Customary Charge for the services performed and the materials furnished;

6. Charges for any services, supply or Hospital confinement which are not considered Necessary Treatment of an Illness;
7. Charges for losses incurred while the individual is in the military, naval, air force or other armed services of any country;
8. Charges for which benefits are not specifically provided under this Policy;
9. Charges for the treatment of teeth, gums or alveolar process, or for dental appliances or supplies used in such treatment, EXCEPT those services listed under the Benefits section;
10. Charges for hearing aids or examinations to determine the need for, or the proper adjustment of, hearing aids;
11. Charges for eyeglasses and contact lenses or Physician's services in connection with eye refractions or any other examinations to determine the need for, or proper adjustment of, eyeglasses or contact lenses;
12. Charges for radial keratotomies, acupuncture (includes, but is not limited to, acupuncture by needle, electrical stimulation, ultrasound, acupressure, laser and articular therapy) or thermography;
13. Charges for, or in connection with, care, treatment or operations which are performed for cosmetic purposes, EXCEPT for the services described in the Benefits section;
14. Charges for hospitalization, services, treatments or supplies furnished by the United States or a foreign



governmental agency unless otherwise prohibited by law;

15. Charges for medical treatment by a Physician for any treatment which is not rendered by or in the physical presence of the Physician;
16. Charges for services provided by a Physician, registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed physiotherapist who ordinarily resides in the same household with the insured individual or who is related by blood, marriage, or legal adoption to the insured individual or his/her spouse.
17. Charges incurred in connection with a Preexisting Illness(es) will be limited as described in the Preexisting Illness(es) section;
18. Charges for reversal of sterilization procedures, either male or female;
19. Charges for Custodial Care or care which is primarily for custodial or domiciliary purposes;
20. Charges for any and all expenses incurred beyond the termination date of coverage unless specifically allowed for by an Extension of Coverage or Continuation of Coverage situation;
21. Charges for educational, instructional, or vocational training except this exclusion does not apply to the expenses described in Benefit #22;
22. Charges for treatment, therapy or related services given to maintain functioning at the level to which it has been restored or when no further practical improvement can be expected;
23. Charges for expenses resulting from modifications made to a home, automobile/van, or other real or personal property. This would include but is not

limited to items such as ramps, elevators, spa, air cleaning or filtration systems and car hand controls;

24. Charges for any drug or medicine which is not approved by the Food and Drug Administration (FDA);

25. Charges for expenses resulting from exercise, diet or weight loss programs or treatment, including nutritional evaluations and food supplements; or facilities providing such treatment, regardless of the reason for the programs or treatment;

26. Charges for cardiac rehabilitation programs or treatment unless the Eligible Charges are incurred within eighteen weeks of hospitazation due to a heart attack, open heart surgery or balloon angioplasty procedures;

27. Charges for routine, periodic or annual examinations or diagnostic tests which are performed primarily for preventative or health screening purposes, EXCEPT those services listed under Benefit #28;

28. Charges for in vitro fertilization or other means of artificial insemination.

29. Charges for expenses resulting from any smoking cessation program or any treatment for tobacco or nicotine dependence.

30. Charges for diagnosis, care or treatment of Developmental Disorders or learning disturbances regardless of age.

PRE-EXISTING CONDITIONS:

For all Employees and Dependents who enrolled for coverage when first eligible, there is a $2,000 maximum



payment for care and treatment of a Pre-existing Illness(es) until:

a. there is a period of 3 months ending after the insured individual's effective date, without any care or treatment for the condition(s), or

b. a period of 12 months after the individual's effective date of coverage.

For all other Employees and Dependents for whom evidence of insurability was required as a condition of being insured, there is a $500 maximum payment for care and treatment of a Pre-existing Illness(es) until:

a. there is a period of 3 months ending after the insured individual's effective date, without any care or treatment for the condition(s), or

b. a period of 12 months after the individual's effective date of coverage.

The maximum payment amounts referenced above for care and treatment of a Pre-existing Illness(es) will be reduced by the amount of benefits paid, if any, under Master Policy

Pre-existing Illness(es) is defined in the Definitions section.

EXTENSION OF COMPREHENSIVE MEDICAL COVERAGE:

If on the termination of the Master Policy the Employee is Totally Disabled by an Illness, coverage for the individual will be extended during the subsequent period of continuous Total Disability, but for not longer than 12 months after the date of termination, solely for Illnesses incurred prior to the termination of the Master Policy.

COORDINATION OF BENEFITS:

If a person is covered for medical care or treatment benefits under any other plan of coverage:

a. for individuals in a group, whether on an insured or uninsured basis;

b. provided under Medicare or any other governmental program; or

c. provided in group, group-type and individual "no-fault" and traditional "fault" type contracts,

the benefits of this insurance option may be reduced so that during the calendar year up to, but not more than, 100% of the person's medical or dental expenses (at least a portion of which is covered under one or more of such plans) will be paid by all such plans.

Where payment has been made under any other plan when it should have been made under this insurance option, the Insurer will have the right to adjust the payment directly with the other insurance company, organization, or person making such other payment.

If a person is covered for medical care or treatment under any other plan, as defined above, the order of benefit determination (primary vs. secondary) will be determined by using the first of the following rules which apply:

1. DEPENDENT/NON-DEPENDENT The plan that covers the person as an employee, member or subscriber will be primary.

2. DEPENDENT CHILD/PARENTS NOT DIVORCED OR SEPARATED —



i. The plan of the parent whose birthday (month and day) falls earliest in the year will be primary.

ii. If both parents have the same date of birth, the Plan that covered a parent the longest will be primary.

iii. If the other Plan does not have the rules described in i. and ii. above , but instead has a rule based on the gender of the parent, the rule of the gender Plan will determine primacy.

3. DEPENDENT CHILD/PARENTS DIVORCED OR SEPARATED —

i. First, the Plan of the parent with custody of the child.

ii. Then, the Plan of the spouse of the parent with custody of the child.

iii. Finally, the Plan of the parent not having custody of the child.

EXCEPT if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and the individual obligated to pay or provide health care benefits has actual knowledge of that obligation, that parent's Plan will be primary.

4. ACTIVE/INACTIVE EMPLOYEE — The Plan that covers a person as an active employee (not laid off or retired) will be primary.

5. LONGER/SHORTER LENGTH OF COVERAGE — If none of the above rules determine primacy, the Plan that has covered an

employee, member or subscriber the longest will be primary.

## EXAMPLES SHOWING HOW THE INSURANCE OPTION WORKS:

### EXAMPLE NO. 1

*Example No. 1 illustrates how the insurance option works when no other coverage is involved.*

| | *Option A* | *Option B* | *Option C* |
|---|---|---|---|
| Hospital Room and Board ..... | $ 600.00 | $ 600.00 | $ 600.00 |
| Hospital Other Charges..... | 425.00 | 425.00 | 425.00 |
| Anesthesia..... | 100.00 | 100.00 | 100.00 |
| Surgery..... | 400.00 | 400.00 | 400.00 |
| Private Nurse ..... | 250.00 | 250.00 | 250.00 |
| Total Expenses..... | $1,775.00 | $1,775.00 | $1,775.00 |
| Less Deductible ..... | -100.00 | 250.00 | 500.00 |
| Total Eligible Expenses ..... | $1,675.00 | $1,525.00 | $1,275.00 |
| *Insurance pays 80% ..... | $1,340.00 | $1,220.00 | |
| 75%..... | | | $ 956.25 |
| Insured pays 20%..... | $ 335.00 | $ 305.00 | |
| 25%..... | | | $ 318.75 |

### EXAMPLE NO. 2

*Example No. 2 assumes the same expenses as Example No. 1 but the individual is also covered by other insurance which, according to the established Coordination of Benefits rules, is required to pay its benefits first. Although this example shows that the insured pays nothing, it is possible under certain situations, for the Insured to be obligated for some payment.*



| | *Option A* | *Option B* | *Option C* |
|---|---|---|---|
| Total Expenses..... | $ 600.00 | $ 600.00 | $ 600.00 |
| Assume Medicare (or other ..... Insurance) plan pays | 1,000.00 | 1,000.00 | 1,000.00 |
| This Insurance pays ..... the balance up to above. | 775.00 | 775.00 | 775.00 |
| Insured pays ..... | Nothing | Nothing | Nothing |

## MEDICAL RECORDS TO SUBSTANTIATE CLAIMS:

It is necessary to keep separate records of your expenses with respect to yourself and each of your Dependents. Original copies of all itemized statements are necessary to support a claim when State Farm is the primary carrier.

Itemized statements should always include:

1. Name of person or organization making the charge, i.e. doctor, Hospital, nurse, drugstore, etc.
2. Date of treatment or purchase.
3. Type of treatment performed or materials furnished.
4. Amount charged.
5. Name of patient.
6. Name and prescription number of drugs or medicine

A doctor's statement must be provided on request.

Cash register receipts, cancelled checks, money order stubs, etc., are not acceptable as bills for medical expenses.

## TERMINATION OF INSURANCE:

The Master Policy may be terminated by the Insurer on any premium due date upon written notice to the

Policyholder at least 31 days in advance if the enrollment is below 75% of the total number of Employees eligible for insurance.

The Insurer may also terminate the Master Policy at the end of the grace period (as specified in the Master Policy) if premiums due have not been paid.

The Master Policy may be terminated by the Policyholder at any time.

Your insurance may be terminated by the Policyholder if you submit, or cause to have submitted in your behalf, a claim containing a material misrepresentation.

Your medical insurance will automatically terminate on the earliest of the following dates: the date the Master Policy terminates, the last day of the calendar month coincident with or next following the date of termination of employment, the date of the expiration of the last period for which you have made a contribution or allocated Flexible Compensation dollars, the last day of the month in which you otherwise cease to be eligible for insurance, or the last day of the month in which you enter military, naval, air force or other armed services of any country. The insurance for a Dependent automatically terminates on the earliest of the following dates: the date coverage for Dependents is terminated under the Master Policy, the date your insurance terminates, the last day for which your Dependent's premium has been paid, with regard to a spouse the last day of the month during which you become divorced or legally separated, the last day of the month in which the Dependent enters the military, naval, air force or other armed services of any country, and with regard to a child the last day of the month in which the child marries or ceases to receive over 50% of his/her annual support from his/her parents, or the last day of the calendar year during which the child attains age 23



or becomes eligible for coverage as a State Farm Employee or agent.

The maximum age limit for children does not apply to a child who is on the date he/she attains the maximum age, and continues to be, both (a) mentally or physically incapable of earning his/her own living and (b) chiefly dependent on the Employee for over 50% of his/her annual support and maintenance as long as such dependency and incapacity continues if due proof of the continuance of such dependency and incapacity is furnished to the Insurer as it may reasonably require. The Insurer will request and require proof of the incapacity and dependency of such a Dependent as of the date of claim but may not request or require such proof sooner than two months prior to the date on which the person attains the maximum age. In, the absence of proof submitted within 31 days of such inquiry, the Insurer may terminate coverage of such person at or after attainment of the limiting age. In the absence of such inquiry, coverage of any disabled and dependent person shall continue through the term of such policy or any extension or renewal thereof.

CONVERSION:

If your coverage terminates while the Master Policy continues in force, you may be eligible to convert your coverage and the coverage of your Dependents, who were insured with you to a conversion policy. In addition, conversion is available to children who marry or reach the maximum age limit and to your former spouse in the event of dissolution of your marriage or upon your death. It is also available at the end of any continuation of coverage time period.

A conversion policy will not be issued to an insured individual who is eligible for Medicare or who has similar benefits provided by another plan.

Application for conversion must be made within 31 days after coverage under the group terminates. If you are eligible for conversion and apply within the time allowed, a conversion policy will be issued without medical evidence of insurability.

The benefits of the individual policy will not be the same and may be considerably less than the benefits of the Master Policy. For information secure a Conversion Application from the Regional Office Personnel Department.

PREFERRED PROVIDER ORGANIZATION:

Preferred Provider means a Hospital or other health care facility recognized as such by State Farm and AFFORDABLE Health Care Concepts. Names and addresses of Preferred Providers can be obtained from the Provider Directory.

When Eligible Charges are incurred through a Preferred Provider, the Benefit Percentages will be increased 10% (but not to exceed 100%) for such Eligible Charges which exceed the Deductible except that the Benefit Percentages for Eligible Charges incurred for the care or treatment of alcohol abuse, drug abuse, or Mental or Nervous Disorders will be increased 10% for the first $8,000 of Eligible Charges in any calendar year and thereafter will be payable at 80% for Option A and B and 75% for Option C. When a Benefit specifies a maximum allowance (for example dollar amount) and the maximum has been reached, the insured Individual is responsible for charges above the Benefit maximum amount.



This Benefit does not apply to the Benefits described in item #6 in the Benefits Section (see page 4215).

This provision shall become effective on the date designated by the Policyholder and the benefits provided by the provision shall be applicable to Eligible Charges incurred while the provision is in effect. This provision shall terminate on the date designated by the Policyholder.

GENERAL INFORMATION:

You have 20 days from the date of commencement of the loss to give the Insurer written notice of injury or sickness upon which you base your claim. Following notice of injury or sickness, you will receive a claim form so that you may file proof of loss.

You have 90 days after the date of loss to furnish proof of loss to the Insurer.

If you do not furnish notice or proof within the time allowed, your claim will still be considered if you show that it was not reasonably possible to furnish the notice or proof within the time allowed and that the notice or proof was furnished as soon as was reasonably possible. However, in no event will a claim be considered if proof of loss is submitted later than 15 months after the date of loss.

Any benefits provided in the Master Policy will be paid immediately after receipt of proof of loss. All benefits are payable to you unless subject to a valid assignment. If you die before the Insurer makes payment of the benefits, payment will be made to your estate; or, at the Insurer's option, to your widow or widower, if living; otherwise to your living children, if any; otherwise to your parents, if living.

The Insurer reserves the right to allocate the Deductible amount to any Eligible Charges and to apportion the benefits to the Employee and any assignees.

No action at law or in equity shall be brought to recover on the Master Policy prior to the expiration of 60 days after proof of loss has been filed, nor shall action be brought at all unless brought within 3 years from the expiration of the time within which proof of loss is required by the Master Policy.

The Insurer reserves the right and opportunity to examine the person whose injury or sickness is the basis of claim as often as it may reasonably require during pendency of the claim.

This insurance is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

If you should be unable to work because of disability, leave of absence, or temporary layoff, or should you be retired, inquire of the Policy-holder as to your rights, if any, under the Master Policy.

CLAIM AND REVIEW PROCEDURE:

When you need to file a claim,

HOW TO FILE A CLAIM:

1. Contact the Group Insurance Benefits Specialist in your Personnel Department for the appropriate claim form. It is important that the form be filled out carefully and completely since missing or incomplete answers may delay payment.
2. You must complete and sign the claim form (one form per patient).



3. A separate Physician/supplier statement is sometimes required. If so, you will be given the form to be completed by the doctor.
4. Return the completed form(s) and available medical bills documenting the charges incurred to the Group Medical Insurance Division, State Farm Mutual Automobile Insurance Company, Bloomington, Illinois.

PROCESSING CLAIMS:

The Group Medical Insurance Division will,

1. Review the claim form for completeness, and
2. Determine if your claim meets the provisions of the Master Policy. This review process usually takes about 30 days from the date the claim was filed. When more time is necessary, the Group Medical Insurance Division will have up to 90 days (after receipt of the claim) to make a determination.

Special circumstances may require a further extension of time for processing the claim. In these cases, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. The extension notice will indicate,

a. The special circumstances requiring an extension of time, and

b. The date which the Group Medical Insurance Division expects to render the final decision.

This extension will not exceed 90 days from the end of such initial period.

PAYMENT OF CLAIM:

If payment is authorized, the Group Medical Insurance Division will release whatever benefits are payable.

DENIAL OF CLAIM:

If your claim is denied, the Group Medical Insurance Division gives you written notice of the denial. The written notice provides the following:

1. The specific reason or reasons for the denial.
2. Specific reference to pertinent plan provisions on which the denial is based.
3. A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
4. Appropriate information as to the steps to be taken to submit the claim for review.

REVIEW PROCEDURE:

If your claim is denied, you or your authorized representative may request a review of your claim. You will need to put your request in writing and submit it to the Group Insurance Benefits Specialist. The request should include documents, reports, or other evidence to support your position. To help you prepare your request, you may examine any pertinent plan documents. Your request for review must be made within 60 days of the receipt of notice of the denial of your claim. If such a request is not made within 60 days, you will be deemed to have waived your right to a review by the Plan Administrator.

The Group Insurance Benefits Specialist will forward your request for review along with the entire file to the



Corporate Benefits and Services Division of General Personnel, Corporate Headquarters. They will make a decision not later than 60 days after the request for review is submitted, unless special circumstances require an extension of time for processing. In this case, a decision shall be rendered as soon as possible, but not later than 120 days after receipt of the request for review. The decision on review will be in writing and will include specific reasons for the decision. It will be written in readily understandable language and will refer to the pertinent plan provisions on which the decision is based. If the decision on review is not furnished within the time limits described in the preceding paragraph, the claim shall be deemed to be denied on review.

## SECTION III

## HEALTH MAINTENANCE ORGANIZATION

State Farm employees may choose a health maintenance organization (HMO) as an alternative health care choice. In general, the primary differences between an HMO and Group Medical Insurance are that claim forms need not be completed when seeking medical care, health care is provided by a physician associated with the HMO, deductibles are sometimes not associated with health care provided, and treatment by providers not associated with the HMO must be by referral from an associated physician. Treatment outside of the service area is restricted to emergency care. (There may be other differences that are not noted here.)

NOTE: YOU ARE ELIGIBLE TO PARTICIPATE IN AN HMO ONLY IF YOU LIVE IN THE SERVICE AREA FOR THE HMO.

Upon request, information will be provided to any employee interested in the HMOs listed. Information in the form of

written materials concerning (a) the nature of services provided to members; (b) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participating in the HMO) and circumstances under which services may be denied; (c) the procedures to be followed in obtaining such services; and (d) the procedures available for the review of claims for services which are denied in whole or in part.

Requests for any of the information listed in the above paragraph may be directed to the Plan Administrator and the Plan Administrator will forward all requests to the appropriate HMO carrier. A brief summary of each HMO's benefits, grievance procedures and procedures for submitting eligible expenses appears in the appendix.

Although State Farm Mutual Automobile Insurance Company is the Plan Administrator and Plan Sponsor for the Group Medical Plan (including HMO alternatives), any and all benefit determinations will be made by each individual HMO according to its operating procedures.

TERMINATION OF HMO BENEFITS:

Coverage under any HMO offered may terminate for any of the following reasons:

1. Nonpayment of monthly premium or co-payments.
2. Expiration of the month in which a subscriber becomes ineligible.
3. Inability to establish and maintain a satisfactory physician/patient relationship.
4. Fraud or deception knowingly committed by the enrolled subscriber.
5. Misuse ofthe HMO identification card.



6. Disruptive, threatening, unruly, abusive and/or uncooperative behavior.

SOURCES OF CONTRIBUTION:

The premiums for the HMO coverage are shared by the employee and State Farm. Your share of the premium may be paid with pre-tax (flexible compensation) dollars according to the terms of the State Farm Insurance Companies Flexible Compensation Plan for U.S. employees, or with after-tax dollars deducted from your paycheck.

State Farm pays at least 50% of the HMO premium amount. In some instances, State Farm could pay more than 50% of the premium amount. This may be necessary to allow flexibility in HMO pricing and equity for all employees participating in the Group Medical Insurance option.

For more detailed information on HMOs available in your area, see the Appendix.

## HEALTH MAINTENANCE ORGANIZATION APPENDIX

THIS APPENDIX TO THE HMO SECTION IS NOT MEANT TO BE ALL INCLUSIVE OF BENEFITS AND RESTRICTIONS PROVIDED BY THE HMO. FOR A SCHEDULE OF ALL BENEFITS AND RESTRICTIONS, PLEASE CONTACT THE PLAN ADMINISTRATOR AND REQUEST ADDITIONAL INFORMATION. THE HMO WILL BE ASKED TO SEND MORE DETAILED INFORMATION TO YOU.

On the following pages we have tried to describe the benefits available under the various HMO options.

This information has been obtained directly from the HMO's contract or HMO's Representative. If the following information contains any statements that disagree with the HMO contract, then the HMO contract shall govern.